PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
		495417	B. WING _			C <b>03/05/2019</b>
NAME OF PROVIDER OR S  CARRINGTON PLACE				STREET ADDRESS, CITY, STA 514 NORTH MAIN STREET RURAL RETREAT, VA 24		03/03/2019
PREFIX (EAC	H DEFICIENCY M	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	DATE
E 000 Initial Com	ments		E 0	00		
survey wa 03/05/19. complianc Requireme complaints	s conducted 0 The facility was e with 42 CFR ent for Long-To	gency Preparedness 2/26/19 through as in substantial Part 483.73, erm Care Facilities. Two ated during the survey.	FO	00		
survey wa Complaint Correction following F	s conducted 2 s were investi s are required ederal Long T	are/Medicaid certification /26/19 through 3/5/19. gated during the survey. for compliance with the ferm Care requirements. rvey/report will follow.				
113 at the consisted closed rec	time of the su of 26 current ord reviews. Self-Admin Me	ertified bed facility was rvey. The survey sample Resident reviews and 2 ds-Clinically Approp	F 5	54		4/19/19
medication defined by this practic This REQU by: Based on	is if the interdi §483.21(b)(2 e is clinically JIREMENT is staff interview	o self-administer sciplinary team, as li(ii), has determined that appropriate. Inot met as evidenced In facility document and review, the facility staff		Resident #3 has be Director of Nursing/I	-	e
failed to as self-admin	ssess 1 of 28 ristration (Resi	esidents for medication dent #3).		Practitioner for the a self-administer medi #3 s care plan has Administrator/Design results of the assess	bility to safely cations. Resident been updated by the to reflect the sment.	
self-admin	istration of sal	assess Resident #3 for ine nasal spray.  PLIER REPRESENTATIVE'S SIGNATUR		Self-administration of documented by the I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/18/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING _				05/0040
NAME OF D	ROVIDER OR SUPPLIER	455417		67	FREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019
NAME OF PI	ROVIDER OR SUPPLIER						
CARRING	TON PLACE AT RURAL	RETREAT		51	4 NORTH MAIN STREET		
				R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554	Continued From pag	no 1		. E 4			
1 004	Continued From pag		F 5	004			
					the Medication Administration Record.		
		ord of Resident #3 was reviewed					
		19. Resident #3 was			Residents will be interviewed and those	-	
		ty 4/5/17 and readmitted			that wish to self-administer medications	3	
	_	es that included but not limited			will be assessed by the Director of		
	to respiratory failure				Nursing/Designee and Practitioner to		
	' '	s legs syndrome, diastolic			determine their ability to safely		
	heart failure, atrial fibrillation, obstructive sleep				self-administer their medications. Care		
	apnea, hypokalemia			plans will be updated by the			
		thy, gastro-esophageal reflux			Administrator/Designee as indicated		
		mia, hypothyroidism, major			necessary to reflect the result of the		
		insomnia, anxiety, chronic			assessment.		
		min D deficiency, benign					
		morbid obesity, hypertension,			Director of Nursing/Designee provided		
		oulmonary disease, type 2			education to the Licensed Nurses on		
	diabetes mellitus, na	isal congestion, and			04/17/19, 04/18/19 and 04/19/19		
	migraines.				regarding the resident ☐s right to		
	D . 1 . 1 1/01				self-administer medications once		
		Il minimum data set (MDS)			assessed by the Director of	_	
		assessment reference date			Nursing/Designee and Practitioner as s		
		essed the resident with a			to self-administer their own medication	s.	
		y for mental status) as 15. No			Interviews will be conducted by the		
		, behaviors affecting others or			Administrator/Designee for three (3)		
	psychosis.				residents with Brief Interview of Mental		
	A mbumining	to d 4/24/40 mond			Status Score of 10 or greater weekly for		
	A physician order da				three (3) months to determine if they w		
	, , ,	g (milligrams) bid (twice a			to self-administer their medications. Th		
		ne nasal spray prn (as			review will also ensure that if they desir		
		idminister. May keep at			to self-administer meds, the resident ha	38	
	_	el tid (three times a day)			been assessed by the Director of		
	prn-knees/hips [4g (	grams)j amraigia."			Nursing/Designee and Practitioner to	ara	
	The acompanies	ad the aliminal was and and			determine if they can safely do so and		
		ed the clinical record and			permitted to self-administer their meds		
	was unable to locate				The regulte of the interviews and review	•••	
	self-administration of				The results of the interviews and review	vs	
		ated 1/31/19 5:24 p.m. did			will be discussed by the Director of		
		tion of medication self-			Nursing/Designee monthly for three (3)	1	
		d the departmental note of			months at the Quality Assurance		
	2/1/19 at 4:52 a.m., 4	4:13 p.m., or 4:59 p.m.			Performance Improvement Committee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495417	B. WING _				05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368	1 00.	00.20.10
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 554	2/20/19 did not have self-administration ide  The surveyor intervie #1 on 3/4/19 at 3:43 p where the self-adminiassessment was locatime the resident wan nurse instructed her cand the medication with medication administration administration administration administration and the surveyor and L.P. 2019 MARs. The sall but there was no doc had self-administered. The surveyor informed the corporate register concern and requeste self-administration of 3:45 p.m.  The surveyor reviewer "Self-Administration or read in part, "Resider self-administer medicate and has determined appropriate and safe 2. In addition to gene decision-making capa practitioner will perforassessment, including	ensive care plan dated medication entified.  wed licensed practical nurse o.m. The surveyor asked istration of medication ated. L.P.N. #1 stated each of the saline spray, the on the use of the medication ras then documented on the ation record (MAR). Both and the saline spray the on the use of the medication ras then documented on the ation record (MAR). Both and the saline spray in eorder had been entered umentation that the resident of the medication.  In the director of nursing and red nurse of the above red the policy on medications on 3/4/19 at red the facility policy titled of Medication." The policy on the the right to reations if the interdisciplinary that it is clinically for the resident to do so. real evaluation of	F	554	Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		
	medication labels; b. purpose and proper of time for his or her me	comprehension of the losage and administration					

PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING				C ( <b>05/2019</b>	
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE  14 NORTH MAIN STREET  RURAL RETREAT, VA 24368	<u> </u>	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 554	medication; and d. ab major adverse conser- medications.  3. If the team determing safely self-administer that the staff and praces findings and the choice able to self-administer that the staff will determine with the staff will determine will determ	or otherwise administer) the bility to recognize risks and quences of his or her sines that a resident cannot redications, the nursing he resident's medications. Stitioner will document their ces of residents who are remedications. Fing residents, the nursing ho will be responsible (the g staff) for documenting that ten. review the self-administered each nursing shift, and they information to the MAR kept, appropriately noting that	F	554				
F 557 SS=D	of nursing, the corpor MDS regional registe executive of the abov p.m.  No further information exit conference on 3/3 Respect, Dignity/Righ CFR(s): 483.10(e)(2)  §483.10(e) Respect a The resident has a rigand dignity, including  §483.10(e)(2) The rig possessions, including	and Dignity. ght to be treated with respect	F	557			4/19/19	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	03/03/2019	
				514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 557	Continued From page	e 4	F 5	57			
F 557	upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and observation, the facility staff failed to provide personal privacy for 1 of 28 residents in the survey sample (Resident #34).  The findings included:  Resident #34 was readmitted to the facility on 9/12/15 with the following diagnoses of, but not limited to anemia, neurogenic bladder, urinary tract infection, dementia, Multiple Sclerosis and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #34 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on		F 5	For Resident #34, the survey #1 stepped into the shower reclosed the door at the time of There was no adverse effect resident.  Bathing observations have be conducted for East wing and by the Administrator/Designe further issues with Dignity and during resident showers.  Education has been provided Director of Nursing/Designee staff on 04/17/19, 04/18/19 a including the certified nursing that give showers regarding resident showers regarding residents.	For Resident #34, the surveyor and RN #1 stepped into the shower room and closed the door at the time of the concern. There was no adverse effect to the resident.  Bathing observations have been conducted for East wing and West wing by the Administrator/Designee to identify further issues with Dignity and respect during resident showers.  Education has been provided by the Director of Nursing/Designee to nursing staff on 04/17/19, 04/18/19 and 04/19/19 including the certified nursing assistants that give showers regarding maintaining dignity and respect during bathing and		
	and RN #1 (registere #34's room. The resi a CNA (certified nurs room stated that the hallway getting a sho #1 went across the h knocked on the door, the door, the surveyoresident sitting on a son. The resident was	mately 10 am, this surveyor d nurse) went into Resident dent was not in the bed and ing assistant) that was in the resident was across the wer. This surveyor and RN allway and the surveyor When the CNA#1opened or and RN #1 observed the shower chair with only a shirt is left uncovered and hat was in the hallway to see		be conducted by the Director Nursing/Designee on East W Wing for three (3) resident sh weekly for three (3) months to dignity and respect are maint residents remained covered a unexposed.  The results of the interviews will be discussed by the Direct Nursing/Designee monthly for months at the Quality Assura Performance Improvement C	ing and West lowers/baths o ensure ained and and and reviews otor of r three (3) nce		
	her. RN #1 stated to	the surveyor, "She should door until the resident was		Meeting (QAPI). The interdisc team (IDT) will make recomm	ciplinary		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495417	B. WING _			l	/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			, 33.	30.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 558 SS=D	the above documented pm in the conference.  No further information surveyor prior to the expension of the preferences except when the expension of the expensio	the administrative team of ed findings on 3/1/19 at 5:33 room.  In was provided to the exit conference on 3/5/19. odations Needs/Preferences  that to reside and receive with reasonable sident needs and then to do so would or safety of the resident or	F 5	5557	for revisions as indicated necessary to sustain substantial compliance.		4/19/19
	by: Based on resident in clinical record review honor 1 of 28 residen preferences to sleep home-like environme The findings included The facility staff failed Resident #19's reque The clinical record of 2/26/19 through 3/5/1 admitted to the facility 1/19/19 with diagnose limited to methicillin re-	in a recliner and create a  nt for the resident.  : I to provide a recliner per			Resident #19 was provided a recliner and his bedside as well as an alternating air mattress for comfort by the Administrator/designee during the surve process. Resident #19 was interviewed the Administrator/Designee and verbalist satisfaction with the recliner and the mattress.  Resident interviews have been conduct by the Administrator/Designee with cognitively intact residents (Brief Intervof Mental Status Score of 10 or greater ensure that needs and/or preferences a reasonably accommodated.  Education has been provided to the Interdisciplinary Team and nursing staff the Administrator/Designee on 04/17/19	r ey I by zed ted iew ) to are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _				05/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	03/2013
				514	4 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT			JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page 6 Resident #19's 5-day minimum data set (MDS)		F 5	558	04/18/19 and 04/20/19 . The education		
	(ARD) of 1/22/19 ass BIMS (brief interview There were no asses	assessment reference date essed the resident with a for mental status) as 13/15. sed signs or symptoms of ffecting others or psychosis.			includes resident rights to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Resident interviews will be conducted by the Administrator/Designee for three (3)	t□s	
	The surveyor reviewed the current comprehensive care plan for alteration in skin integrity dated 12/11/18. The care plan read, "I prefer to sleep in my recliner."  The surveyor observed the resident and the room on each day of the survey from 2/26/19 through 3/5/19. The surveyor did not observe a recliner in the resident's room on 2/26/19 through 2/28/19.				residents weekly for three (3) months to ensure that the facility staff are providing reasonable accommodation of resident needs and preferences.		
					The results of the interviews and review will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee		
	at 9:19 a.m. The resiget around the room help. The resident st out of the chest but the gets my clothes out or resident was asked a and asked if the bed	wed the resident on 2/28/19 ident was asked if he could without asking for staff's ated, "I can get my clothes he girl that gives me a bath if the wardrobe." The bout the comfort of the bed was large enough. The ually slept in his recliner at			Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.	5	
	1:54 p.m. Resident # Wound care performs wound care nurse sta in both legs but has a elevated. The wound resident usually would was no recliner in the nurse stated the resident at some time had	ed wound care on 2/28/19 at 19 was observed in bed. ed to right great toe. The ated the resident had edema hard time keeping the legs care nurse stated the d sit in a recliner but there is room. The wound care dent had a recliner at home d a recliner in his room. The ated she would try to get the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495417	B. WING		C 03/05/2019	
	ROVIDER OR SUPPLIER	AL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	03/03/2019	
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F 558	The surveyor review from January 2019 1/3/19 12:20 p.m., documented that reassistance needed  Departmental note read "rsdt (resident entire shift."  Departmental note read in part "Rsdt is (refused) to lay down Departmental note in part "Rsdt ref to go Departmental note in part "Rsdt ref to gwent to bed at approbut was letting feet numerous requests Departmental note in part "Rsdt is sittinuntil now."  Departmental note read in part "Rsdt is sittinuntil now."  Departmental note read in part "Rsdt has to go to bed."  Resident #19 was a.m. The surveyor resident's room. Recliner. Now I need The surveyor inform director of nursing, nursing, the corporagional executive in the surveyor regional executive in the s	and see about a bariatric bed.  wed the departmental notes through February 2019. On the director of nursing shab was notified of increased in repositioning in his recliner.  dated 1/25/19 at 6:37 a.m. b) sat up in chair at bedside this dated 1/29/19 at 5:51 a.m. s sitting up on side of bed ref vn." dated 2/2/19 at 5:58 am read go to bed this shift." dated 2/7/19 at 7:40 a.m. read go to bed most of shift finally rox (approximately) 330 a.m. dangle off of bed after	F 55	8		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		405447	D WING				C
		495417	B. WING			03/	05/2019
NAME OF PR	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING.	TON PLACE AT RURAL I	RETREAT			514 NORTH MAIN STREET		
OARRINO	TONT LAGE AT NONAL I	KEIKEAI			RURAL RETREAT, VA 24368		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 558	Continued From page	. 0					
F 330	Continued From page	: 0		558	3		
	No further information exit conference on 3/5	was provided prior to the 5/19.					
F 565	Resident/Family Grou	ip and Response	F	565			4/19/19
SS=D	CFR(s): 483.10(f)(5)(i	•					
	§483.10(f)(5) The res	ident has a right to organize					
	and participate in resi	dent groups in the facility.					
		ovide a resident or family					
	-	vith private space; and take					
		h the approval of the group,					
		d family members aware of					
	upcoming meetings in	-					
		ther guests may attend ily group meetings only at					
	the respective group's						
		provide a designated staff					
		ed by the resident or family					
		and who is responsible for					
		and responding to written					
	requests that result from	· ·					
	(iv) The facility must of	consider the views of a					
	resident or family grou	up and act promptly upon					
	_	commendations of such					
		sues of resident care and life					
	in the facility.	e able to demonstrate their					
	response and rational						
		e construed to mean that the					
	• ,	nt as recommended every					
	request of the residen	_					
	§483.10(f)(6) The res						
	participate in family g	roups.					
	§483.10(f)(7) The res	ident has a right to have					
	family member(s) or o						
	representative(s) mee	et in the facility with the					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C <b>3/05/2019</b>	
NAME OF PE	ROVIDER OR SUPPLIER	1001	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2019	
INAME OF T	COVIDER OR OUT FILE						
CARRING	TON PLACE AT RURAL	RETREAT		514 NORTH MAIN STREET			
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 565 Continued From page 9		e 9	F 56	65			
	residents in the facilit This REQUIREMENT by: Based on Resident i	epresentative(s) of other ry.  is not met as evidenced  interview and staff interview to provide adequate space		An adequate space has been for Resident Council Meetings.			
		meetings expressed by the					
	facility's Resident Co			Resident interviews have been	conducted		
	Findings included:			by the Administrator/Designee Resident Council Members on ensure that the space provided	with 04/17/19 to		
	On 02/28/19 at 11:05	AM the surveyor asked the		Resident Council Committee M	leetings to		
	Residents during Res	sident council meeting "Is		be held has adequate space a	n <b>d</b>		
	there enough space	for everyone who wants to		temperature.			
	attend?" All in attend	ance: Resident #7, Resident					
	#87, Resident #79, R	lesident #64, and Resident		Education has been provided t	o the		
	#16 voiced; "This roo	m is too small and it's hot in		Interdisciplinary Team by the			
	here". The surveyor a	asked the Residents in		Administrator/Designee 04/17/	19,		
	attendance "Do you r	meet in this room often for		04/18/19 and 04/19/19 regarding	ng ensuring		
	Resident council med	etings?" The Residents in		that the space provided for Re	sident		
	attendance voiced th	at they meet in the room		Council Committee Meeting is	large		
	often for their monthly	y meetings.		enough to accommodate resid	ents and		
				their families that wish to atten	d.		
	On 02/28/19 at 1:45F	PM the surveyor notified the		Observation of Resident Coun	cil		
	administrator of the F	Resident council members'		Committee Meeting will be con	ducted by		
	concern of inadequat	te space during the meeting		the Administrator/Designee mo	onthly for		
	that commenced on 0	02/28/19 at 11:05AM. The		three (3) months to ensure that	t the space		
	administrator voiced	that the only reason they met		provided for meeting accommo	odates		
	in the classroom is be	ecause they needed a		those residents/families that w	sh to		
	private room for the r	neeting with the surveyor		attend.			
	and the dining rooms	and activity rooms are not					
	enclosed.			The results of the interviews ar			
				will be discussed by the Direct			
		n regarding this issue was		Nursing/Designee monthly for			
	provided to the surve	y team prior to the exit		months at the Quality Assurance			
	Conference on 03/05	/19.		Performance Improvement Co			
				Meeting (QAPI). The interdisci			
				team (IDT) will make recomme			
				for revisions as indicated nece	ssary to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C 03/05/2019		
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP C 514 NORTH MAIN STREET RURAL RETREAT, VA 24368				
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F 565	Continued From page 10		F 5	sustain substantial complia	ınce.			
				580		4/19/19		
	consult with the resic consistent with his or representative(s) who (A) An accident invoresults in injury and physician intervention (B) A significant character of the characte	mediately inform the resident; dent's physician; and notify, in her authority, the resident ten there is-living the resident which that the potential for requiring on; inge in the resident's physical, cial status (that is, a sth., mental, or psychosocial interestening conditions or is); reatment significantly (that is, a e an existing form of verse consequences, or to rim of treatment); or insfer or discharge the cility as specified in station under paragraph (g) in, the facility must ensure that the facility must ensure the facility of the facility must ensure the facility of the facility must ensure the facility of t						

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 580	Continued From pag	e 11	F 5	80			
		mailing and email) and					
	that is a composite of §483.5) must disclos its physical configural locations that compripart, and must specification changes between under §483.15(c)(9). This REQUIREMENT by:  Based on staff intervand facility documen notify physician or recondition for 5 of 28 sample (Residents #  The findings included 1. The facility staff (responsible party) or Resident #20 was ac 8/31/18 with the follol limited to heart failure pressure, dementia, depression and respin quarterly MDS (Minir (Assessment referencesident was coded a Interview for Mental spossible score of 15. coded as requiring experiences.	failed to notify the RP f a fall for Resident #20. Imitted to the facility on wing diagnoses of, but not e, diabetes, high blood		For Resident #20, the physicial Responsible Party were notified Director of Nursing/Designee of occurring on 2/25/19 during the process. For Resident #41, the and Responsible Party have be by Director of Nursing/Designet the blood glucose reading >45 2/11/19 at 9:00 pm. There was effect to the resident. For Resithe physician and Responsible notified by the Director of Nursing/Designee regarding madministered on 02/27/2019 at including Zatador and Seroque 2/28/2019 at 9:00 am that Zata Propylene Glycol eye drops we administered. The physician at Responsible Party were notified Director of Nursing/Designee of 04/19/2019 regarding the following glucose readings >450 as well 7:30, 11:30 on 2/1/19, 2/7/19, 2/19/2019 and 2/23/2019, 5:30	ed by the of the fall esurvey exphysician een notified exercised on adverse dent #17, exparty were eds not expand on ador, Mobic, ere not end do by the on or before wing blood : 2/23/19 at 2/10/2019,		

OLIVILIY	OT OIL MEDIO, II LE C	- OLIVIOLO				<u> </u>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495417	B. WING			03/	05/2019
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F 580	Continued From page During the clinical red #20's record, the surve documentation on the Form that was dated 2:35 am" stated: "in floor-previous in be self-transfer from the beside bed." This fall pm with no injuries do On 2/27/19 at approxicalled the resident's Faurveyor asked the R notified when there wa fall. The RP stated 2/25/19, we have been until now. The state in The surveyor notified the above documented 5:33 pm in the confer requested a copy of the facility staff completed policy for notifying the On 3/4/19 at 5:33 pm above documented it team.  On 3/5/19 at approximated the ADON (assert for the above documented it team.	cord review of Resident veyor noted the following and timed for "2/27/19 at resident was observed lying and and was attempting to bed to the wheelchair cocurred on 2/25/19 at 8:30 ocumented by staff.  I occurred on 2/25/19 at 8:30 ocumented by staff.  I imately 10 am, this surveyor RP (responsible party). The RP if she was called or ras a change of condition or		580		e :. P :19 ion s in ctor d fect ents ents ents ents ents ents ents ent	DATE
	received the facility's Resident's Condition	nately 1:30 pm, the surveyor policy titled, "Change in or Status" which stated, " the resident's Attending			thirty (30) days of Electronic Medication Administration Records to ensure that the physician and Responsible Party have been notified of medications not		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	•	•	S1	TREET ADDRESS, CITY, STATE, ZIP CODE			
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F 580	Continued From pag	ge 13	F t	580				
	been a (an)accid residentUnless ot resident, a nurse wil	an on call when there has ent or incident involving the herwise instructed by the I notify the resident's cept in medical emergencies,			administered and that the notifications documented in the clinical record.  Education has been conducted by the Director of Nursing/Designee with	are		
	notifications will be r			Licensed Nurses on 04/17/19, 04/18/19 and 04/19/19 regarding the following topics: ensuring the RP and physician a	are			
		on was provided to the exit conference on 3/5/19.			notified when a resident experiences a and that the notification is documented ensuring that the physician is notified a	;		
	2. For Resident # 41 notify the physician 450.			notification is documented when blood glucose readings meet the notification parameters; ensuring that the physician and Responsible Party are notified who				
	admitted to the facilities included, but were numellitus, hypertension	eview Resident #41 was ity on 11/22/17. Diagnosis not limited to; diabetes on, hyperlipidemia, and			medications are not administered and t notification is documented in the clinica record. Additionally, Licensed nurses o document notification after the notificat	he Il nly ion		
	quarterly MDS (mini with an ARD (assess 12/19/18 included a mental status) summ	patterns) of the Resident's mum data set) assessment sment reference date) of BIMS (brief interview for nary score of 15 out of a			has been completed, not before. A reviwill be conducted by the Director of Nursing/Designee for three (3) resident weekly for three (3) months for the following areas. For residents experiencing incidents or falls in the previous thirty (30) days, the physician	rs.		
	possible 15 points.  The Resident's comincluded the probler complications assochypoglycemia". The but were not limited symptoms) of unstalPerform Accuched abnormal findings to On 03/01/19 at 2:31			and responsible party have been notified of incidents including falls and the notification has been documented. For residents with current physicians□ order for accuchecks and notification parameters, the physician has been notified of blood glucose reading within the previous thirty (30) days that met specific notification parameters and the notification is documented. The physiciand Responsible party have been notified medications not administered and the	ers e an ed			
		rd. Resident #41's physician's			notifications are documented in the	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 580	Continued From page	e 14	F 58	30			
		order dated 08/24/18 which		clinical record.			
	AND AT BEDTIMES I doctor) IF <60 OR >4 Resident #41 EMARS	50". s (electronic medication		The results of the interviews will be discussed by the Direct Nursing/Designee monthly for months at the Quality Assura	ctor of or three (3) nce		
		s) for February revealed that		Performance Improvement C			
	sugar) reading was 4			Meeting (QAPI). The interdisc team (IDT) will make recomm for revisions as indicated nec	nendations		
	notified.	icate that the MD had been		sustain substantial compliand	ce.		
		ed the nursing progress tion record "details" no notes 02/01/19.					
		with the administrative team megarding the concern of an notified.					
	provided to the surve Conference on 03/05 3. For Resident #17, the physician when m	facility staff failed to notify nedications were not en blood sugars were within					
	4/19/16. Diagnoses i gastroesophageal ref mellitus, anxiety, dep chronic pain. On the assessment reference scored 15/15 on the is status and was assess						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 580	Continued From pag	ue 15	F 5	30		
	one tablet by mouth eye drops one drop of Seroquel 50 milligrant bedtime, and propyletimes a day. During clinical record surveyor noted that and Seroquel were dadministered-meds AM Zatador, Mobic, drops were document meds not available."  The resident had a paccuchecks three times and at bedtime (notified 60 or >450). The digreater than 450 at 75	and propylene glycol eye nted as "not administered- ohysician order for nes every day before meals fy MD for BG(blood glucose) locumented blood sugar was 7:30 on February 23, at 11:30, 19, and 23, at 5:30 on				
	physician or nurse p medication omission glucose readings. No say whether the physindividual occurrence the issues noted.  The administrator are notified of the concerduring a summary model.  4. For Resident #51 the physician when a administered and do	ng notes to indicate that the ractitioner were notified of the s or of the high blood lursing staff were unable to sician was notified of any e or was routinely notified of and director of nursing were rns with physician notification neeting on 3/1/19.  In facility staff failed to notify a medication was not cumented that notification in it had not been done.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 580	3/25/18. Diagnoses diabetes mellitus, se dementia, seizure di schizophrenia. On t set assessment with 3/29/18, the resident interview for mental without signs of delir affecting care.  Clinical record review klonopin 1 milligram equal 1.5 milligram bedtime. The MAR record indicated the administered at leas administrations on F 21, 22, 23 and 24. Tof any of these occu the medication nurse AM on 2/27/19 after floor. The nurse tologoing to administer i end of the on time at electronic clinical reconart it was given lat medication notes at administered physicians whether the physician to be administered intended to complete form to notify the physician on the seizure of the physician of the physician to notify the physician to notify the physician to the seizure of the physician to notify the physician to notify the physician to the physician to notify the physician to the physician to notify the physician to the	radmitted to the facility on included hypertension, izures, cerebral palsy, sorder, anxiety, and he quarterly minimum data assessment reference date a scored 9/15 on the brief status and was assessed as itum, psychosis, or behaviors of the with .5 milligram to be medication administration medication had not been at two of the four ordered ebruary 3, 4, 5, 12, 16, 17, the physician was not notified arrences. Surveyors observed the hold the klonopin at 6:30 dropping the klonopin on the at the surveyor she was not at the surveyor she was not at the cord and she did not want to be an aware. The surveyor at she told the physician and an had ordered the dose to the nurse said she as a physician communication and she surveyor asked how often the surveyor asked how of	F5	580				
	physician had not be	an was aware when the een notified. The nurse then office and reported that the						

PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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nu 6:3 co the the wo wo Th or ad wirex see Fass SS=D CF \$4 Th co rein \$4 ac tel an thi pri	30 AM because the introlled medication. The see physician response buld rather have an ould have until 10 A ne physician commutatime and said only liministered. Please th questions. No nutrie and said only liministered. Please th questions. No nutrie and said only liministered and plain the medication overal hours late that exility administration incern as the incide ersonal Privacy/Confer(s): 483.10(h)(1)-83.10(h) Privacy are resident has a right incommodations, metal existence of familiations of familia	le to give the klonopin at surveyors took the log and she could not give surveyor was unable to hear se, but the nurse said she order to give it at 9 so she M to give the medication. Inication form listed no date "6:30 AM medication not refer to [director of nursing] ursing note was made to he being administered to day.  It was made aware of the not occurred on 2/27/19. Indentiality of Records (3)(i)(ii)  Ind Confidentiality. In the personal privacy and representation and medical all privacy includes dical treatment, written and attions, personal care, visits, y and resident groups, but the facility to provide a	F	883			4/19/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	E	03/03/2013	
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F 583	than a postal service §483.10(h)(3) The read confidential personal and med provided at §483.70(federal or state laws (ii) The facility must a Office of the State Lot o examine a resider administrative record law.  This REQUIREMENT by: Based on observation staff failed to provide the 100 hall.  2/27/19 11:00 AM To the east wing 100 hamedication cards on cards were face up a birth dates, room nurwere fully visible on were Resident #89, lunrelated issues (Minhypotension) and an escitalopram 10 mg  The director of nursing concern on 2/27/19 and an escitalopram 10 mg	ered through a means other is sident has a right to secure conal and medical records. The right to refuse the release ical records except as ij)(2) or other applicable allow representatives of the ong-Term Care Ombudsman of the medical, social, and is in accordance with State. This is not met as evidenced on and staff interview facility privacy for two residents on the surveyor was walking in all and observed two empty the medication cart. The find the residents' names, mbers, and drug and dosage both cards. The residents atter added to the sample for dodrine 5 mg twice daily for unsampled resident (daily for anxiety).  The medication of the sample of	F 5	Resident #89 no longer resid facility. The medication cart of two (2) empty medication card hall with exposed resident deinformation were removed fro hallway and secured behind the nurses station during the process on 2/27/19 by the Dir Nursing/Designee.  Facility rounds, and observatibeen conducted on both wing Director of Nursing/Designee further issues with unprotecter resident information.  Education has been provided staff by the Director of Nursing on 04/17/19, 04/18/19 and 04 regarding securing resident in and medical records to maintaconfidentiality of the resident and medical information such	ontaining the ds from 100 mographic m the he counter at e survey fector of ons have s by the to identify d/exposed to current g/Designee /19/19 iformation ain		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 584 SS=D	CFR(s): 483.10(i)(1)-( §483.10(i) Safe Environce The resident has a rig comfortable and home but not limited to rece supports for daily living The facility must prov §483.10(i)(1) A safe, of homelike environment use his or her personate possible. (i) This includes ensureceive care and servirones	ole/Homelike Environment 7) onment. Iht to a safe, clean, elike environment, including iving treatment and g safely.	F 5	medication cards are not left ex the medication cart. Facility rounds/observations will be cor (2) times weekly for three (3) m both wings to ensure that reside personal and medical informatic secured, unexposed and kept of the rounds will also ensure that specific information such as medication cart.  The results of the interviews and will be discussed by the Director Nursing/Designee monthly for the months at the Quality Assurance Performance Improvement Conference (QAPI). The interdiscip team (IDT) will make recomment for revisions as indicated necessustain substantial compliance.	aducted to onths on ent specification is confidential tresident edication op of the dreviews or of hree (3) ee nmittee olinary ndations ssary to	wo fic al. t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 584	(ii) The facility shall of the protection of the or theft.  §483.10(i)(2) Houseld services necessary to and comfortable interest in good condition;  §483.10(i)(3) Clean to in good condition;  §483.10(i)(4) Private resident room, as sponsored in all areas;  §483.10(i)(5) Adequate levels in all areas;  §483.10(i)(6) Comfort levels. Facilities initiated in the sound levels. This REQUIREMENT by:  Based on observation staff failed to provide homelike environment survey sample (Resident #15 was actively sample (Resid	ces not pose a safety risk. exercise reasonable care for resident's property from loss exeeping and maintenance or maintain a sanitary, orderly, rior; end and bath linens that are closet space in each exified in §483.90 (e)(2)(iv); enter and comfortable lighting entable and safe temperature eally certified after October 1, a temperature range of 71 to entable and staff interview facility a clean, comfortable, and for 1 of 28 residents in the	F 5	Resident #15 was provided care, clothes, and bathed as she would during the survey process on 2/27 the Director of Nursing/Designee. Resident #15 was also provided w new mattress for her bed, the roon including floors were cleaned and was removed from beneath the resident   s bed by the Administrator/Designee on 2/27/20 well.	tolerate /19 by ith a n the brief

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 584	Continued From page 21 data set assessment with assessment reference		F 5		s have been		
	date 11/15/18, the restriction brief interview for me assessed as without or behaviors affecting coded as needing as toileting and was ass incontinent of bladde	sident scored 3/15 on the ntal status and was signs of delirium, psychosis, g care. The resident was sistance of 1-2 persons for		Facility rounds/observations conducted by the Administr to ensure that residents cur in the facility are provided v comfortable homelike envir facility rounds/observations provision of care including i care as the resident will allo	rator/Designee rrently residing with a clean, onment. The will include incontinence		
	observed the hallway smelled strongly of unwas closed. The surnoted that the room surine than the hallwal lunch from a tray in the surveyors entered the shift conditions. The resided again smelled door was closed, and room was stronger the The resident appeared to be a soil 02/27/19 at 9:01 AM urine odor was strong surveyor's eyes water what appeared to be The resident had her	ity on 2/26/29, the surveyor where the resident resided rine. The resident's door veyor entered the room and smelled more strongly of y. The resident was eating ne room. On 2:27 at 5 AM, the facility to observe night hallway where the resident dof urine, the resident's at the odor of urine in the an it had been in the hall. The dot obe asleep. There the door was closed and the ger than at 5:30 AM. The red on entry. There was a soiled brief under the bed. eyes closed and was the ger constantly saving the resident resident.		Education has been provided nursing staff by the Director Nursing/Designee 04/17/19 04/19/19 regarding provision comfortable, homelike environmentable, homelike environmentable, homelike environmentable, homelike environmentable, homelike environmentable staff will also removing soiled briefs in a stand minimizing odors. Facily rounds/observations will be the administrator/Director of Nursing/Designee two (2) to three (3) months to ensure staff are providing clean, controlled timely, soiled by removed and odors are minimized to the interview.	r of 0, 04/18/19 and on of a clean, ronment e and bathing he education so include timely manner lity conducted by if imes weekly for that facility omfortable ontinence care riefs are himized and		
	can't, I can't. The odd with the door closed. resident was standing sweatshirt and pants stains- approximately of the shirt and pants was back in bed, weat the soiled brief was s	legs constantly saying I or was apparent in the hall 02/27/19 09:45 AM. The g in the room wearing gray. Both had large wet urine 2X3 foot oval on the back. At 10:39 AM, the resident aring different clothes, and till under the bed. The odor 2/27/19 at 10:47 AM, the		The results of the interview will be discussed by the Dir Nursing/Designee monthly months at the Quality Assurperformance Improvement Meeting (QAPI). The interd team (IDT) will make recomfor revisions as indicated no sustain substantial compliant	rector of for three (3) rance Committee isciplinary nmendations ecessary to		

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		495417	B. WING_			03/	05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL I	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625 SS=E	in the room, the soiled bed, and the mattress said they would take of ombudsman was in the she would check with The ombudsman left is before leaving stating to have been cleaned Staff had reported that new mattress for the odor in the room was appeared to have been soiled brief under the The surveyor reported administrator and direct summary meeting on Notice of Bed Hold Poc CFR(s): 483.15(d)(1) (S483.15(d)(1) Notice nursing facility transfet the resident goes on formursing facility must put the resident or resident specifies—  (i) The duration of the any, during which the return and resume restacility;	rector of nursing and sultant to go to the odor was extremely strong d brief was still under the sappeared to be wet. They care of the issues. The ne facility at noon and said the resident on her rounds. It a note for the surveyor threat the room appeared to be wet. They were looking for a resident. At 1:30 PM, the faint and the floors on cleaned. There was no bed.  If the concerns to the ector of nursing during a 2/27/19. Dolicy Before/Upon Trnsfr (2)  Deed-hold policy and return-before transfer. Before a ters a resident to a hospital or therapeutic leave, the provide written information to an trepresentative that  It state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any;		625			4/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		33,733,720,13	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	Continued From pag	e 23 ich must be consistent with	F 6	25			
	paragraph (e)(1) of the resident to return; and (iv) The information sof this section.  §483.15(d)(2) Bed-hot the time of transfer of	nis section, permitting a d specified in paragraph (e)(1) old notice upon transfer. At f a resident for					
	facility must provide resident representati specifies the duration described in paragra This REQUIREMENT by:	rapeutic leave, a nursing to the resident and the ve written notice which in of the bed-hold policy ph (d)(1) of this section.  I is not met as evidenced					
	and clinical record re to provide written info policy to the resident representative prior t hospital or therapeut must be provided to	o and upon transfer to the ic leave. This information		Residents and/or the responsib have been provided with informa about the bed hold requirements hold policy by the Administrator/during transfers/discharges effer 03/04/2019. Resident #101 no lo resides at the facility.	ation s and bed /Designee ctive		
	during which the resi and resume residence reserve bed paymen the nursing facility's period permitting a re failure affected 5 of 2	ate bed-hold policy, if any, dent is permitted to return the in the nursing facility; the topolicy in the state plan, and policies regarding bed-hold to return. This the residents (Resident #3, tent #19, Resident #74, and		A review has been conducted by Administrator/Designee for the puthirty (30) days to ensure that be information was provided to the and resident responsible party informat should the resident have transfer to the hospital or gone of the the should be the resident have the transfer to the hospital or gone of the should be th	previous ed hold resident n a written had a		
	The findings included  1. The facility staff fainformation to Residerepresentative when	d: ailed to offer bed hold ent #3 and the resident the resident was transferred 9/18, 12/26/18, and 1/4/19.		Education has been provided by Administrator/Designee to the interdisciplinary team and Licens Nurses 04/17/19, 04/18/19 and 0 regarding bed hold requirements policy as well as the process by hold information will be provided	sed 04/19/19 s and which bed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495417	B. WING	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	433417	B: Wiite	6.	TREET ADDRESS CITY STATE 7ID CODE	03/	05/2019
	TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET			
					URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	2/26/19 through 3/5/1 admitted to the facility 1/8/19 with diagnoses to respiratory failure whypercapnia, restless heart failure, atrial filt apnea, hypokalemia, progressive neuropat disease, hyperlipidem depressive disorder, ipain syndrome, Vitam paroxysmal vertigo, nuchronic obstructive pudiabetes mellitus, nasmigraines.  Resident #3's annual assessment with an au (ARD) of 2/6/19 asses BIMS (brief interview evidence of delirium, psychosis.  The departmental not a.m. read "Resident human (emergency room) for with increased confus oxygen, O2 sat (oxyg %, 911 called request resident will not agree (ER). Mother notified service and fire depart to ambulance due to hospital. 6:10 p.m. Howould be sent to anot	Resident #3 was reviewed  9. Resident #3 was  y 4/5/17 and readmitted  s that included but not limited  with hypoxia and  legs syndrome, diastolic  orillation, obstructive sleep  constipation, idiopathic  hy, gastro-esophageal reflux  nia, hypothyroidism, major  nsomnia, anxiety, chronic  nin D deficiency, benign  norbid obesity, hypertension,  ulmonary disease, type 2	F	625	resident and/or resident □s responsible party. Ongoing monitoring will be conducted by the Administrator/Design to ensure that if a resident is transferrer to the hospital or is on therapeutic leave that the required written bed hold information is provided to the resident and/or responsible party. The review were be completed for three (3) residents weekly for three (3) months.  The results of the interviews and review will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.	d e ill vs	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	, ,	COMPLETED		
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	_ RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	<b>.</b>	00/00/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	Continued From pa	ge 25	F 62	55			
	_	nable to locate documentation d and of the bed hold given to entative.					
	p.m. read "Resident liters. Requesting to room). FNP (family	ote dated 12/26/18 at 2:57 's O2 sat 79% on 3 and ½ go to the er (emergency nurse practitioner) notified of ved to send her to er. 911					
	Departmental note dated 12/26/18 at 3:12 p.m. Report called to hospital.						
	Resident admitted to	dated 12/27/18 7:34 a.m. o hospital ICU (intensive care gestive heart failure).					
		nable to locate documentation d and of the bed hold given to entative.					
	read "Resident agre room) for eval (eval status changes, alo O2 sats (saturation	ote dated 1/4/19 at 12:32 p.m. led to go to ER (emergency luation), has had noted mental lung with body twitching, drop in levels). VS (vital signs) D2 sat 88%. Ambulance here let to ER."					
	1	dated 1/4/19 at 7:11p.m. read, to hospital with renal failure."					
	_	nable to locate documentation d and of the bed hold given to entative.					
	The surveyor intervi	ewed the director of nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495417	B. WING			C 03/05/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	<u> </u>	03/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 625	sent with residents whospital. The DON status, pertinent labs sheets, care plan. Tholds were offered to resident representation was not knowledged doesn't address that the surveyor intervial (licensed practical in #3) on 2/28/19 at 4:3 sent with residents whospital. Both state the administrator whospital. Both state to the resident and the same and the hospital. The surveyor review part of the Standard Agreement on 2/28/Policy on bed holds. The surveyor review part of the Standard Agreement on 2/28/Policy read "Name the hospital today. In admitted to the does not pay to hold whatever the resident is in the may move someone However, even if the standard was power of the surveyor review and is admitted to the does not pay to hold whatever the resident is in the may move someone However, even if the	the 4:01 p.m. on information when transported to the stated face sheet, code pratory test results, transfer The DON was asked if bed to the resident and the live. The DON stated she lible about that but nursing the lible about the libre about	F 62	25		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 314 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 625	return as soon as a semi-private room i as the resident still by this nursing hom Medicaid, he or she nursing home servi If the nursing home to the first available when the resident is the resident has the home's decision to Assistance Service complaint with the Certification."  The surveyor inform director of nursing, nursing, the corporaregional executive a (minimum data set) concern on 3/5/19 a No further informati exit conference on  2. The facility staff information to the representative whe transferred to the h  The clinical record 2/26/19 through 3/5 admitted to acute residence on cerephalmited to acute residence on cerephalmited weakness,	bed is available in a In this nursing home as long Ineeds the services provided Ite (and, if the resident is on Ite is eligible for Medicaid Ite (bed in a semi-private room Ite is ready to leave the hospital, Ite right to: appeal the nursing Ithe Department of Medical Its, Appeals Division and file a Ite of Licensure and Ineed the administrator, the Ithe assistant director of Ite registered nurse, the Ite and the regional MDS Ite of Licensure and Ineed the administrator of Ite registered nurse of the above Ite and the regional MDS Ite of Licensure and Ineed the administrator of Ite of the above	F 625		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURA	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 33.55.25.15
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 625	depressive disorder polyneuropathy, hyl reflux disease, adul schizoaffective diso anemia, dysphagia, disease, urinary tracobstructive pulmona deficiency.  Resident #11's qual assessment with an (ARD) of 2/13/19 as BIMS (brief intervier There were no assedelirium, behaviors  The departmental in read "Resident sitting dinning (sic) room, feeling well, very sle over, chest and side 97.1-69-18-130/79 (nurse practitioner) given to send to ER (evaluation) and CT scan of head. Messparty) answering match the clinical record provided to the resident and	ty, hypothyroidism, major ty, bipolar disorder, bokalemia, gastro-esophageal t failure to thrive, rder, urethral stricture, constipation, Parkinson's ct infection, chronic ary disease, and Vitamin  Interly minimum data set (MDS) assessment reference date assessed the resident with a w for mental status) as 15. assed signs or symptoms of affecting others or psychosis.  Interly minimum data set (MDS) assessment reference date assessed the resident with a w for mental status) as 15. assed signs or symptoms of affecting others or psychosis.  Interly minimum data set (MDS) assessment reference date assessed the resident with a w for mental status) as 15. assed signs or symptoms of affecting others or psychosis.  Interly minimum data set (MDS) assessment reference date assessment reference date assessed the resident with a w for mental status) as 15. assessed signs or symptoms of affecting others or psychosis.  Interly minimum data set (MDS) assessment reference date asse	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING _		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	30.00.20.10
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From pag	e 29	F 6	25		
	about bed holds on a routinely doing bed in the hospital. The surpolicy on bed holds.  The surveyor review part of the Standard Agreement on 2/28/7 Policy" read "Name of the hospital today. It and is admitted to the does not pay to hold Whatever the reside the nursing home is the resident is in the may move someone However, even if the hold the bed, the restreturn as soon as a lisemi-private room in as the resident still in by this nursing home Medicaid, he or she nursing home service.	admission but are not hold offers when sent out to reveror requested the facility and the facility and the facility and the facility and the resident has been sent to a few facility. The "Notice of Bed Hold of resident has been sent to a few facility and the resident is on Medicaid the resident is on Medicaid the resident's bed. In the facility and the resident's bed. In the facility and the resident's hold to reserve the bed while hospital, the nursing home else into the resident's room. In the facility and the resident to be discovered as a senilable in a senilable in a this nursing home as long the facility and the facility				
	the resident has the home's decision to the Assistance Services complaint with the O Certification."  The surveyor informed director of nursing, the surveyor informed in t	ready to leave the hospital, right to: appeal the nursing the Department of Medical, Appeals Division and file a ffice of Licensure and the administrator, the the assistant director of				
	regional executive a	te registered nurse, the nd the regional MDS registered nurse of the above				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C <b>03/05/2019</b>		
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		03/03/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 625	Continued From pag	ge 30	F 62	25				
	concern on 3/5/19 a	t 4:26 p.m.						
	No further information	on was provided prior to the 3/5/19.						
	the resident and res	failed to offer a bed hold to ident representative when ransferred to the hospital 20/19, and 2/13/19.						
	2/26/19 through 3/5 admitted to the facil 1/19/19 with diagno limited to methicillin	of Resident #19 was reviewed /19. Resident #19 was ity 11/30/18 and readmitted ses that included but not resistant staphylococcus evated white blood count, and						
	assessment with an (ARD) of 1/22/19 as BIMS (brief interview There were no asse	assessment reference date assessed the resident with a w for mental status) as 13/15. Assed signs or symptoms of affecting others or psychosis.						
	read, "FNP (family r residents confusion received to send res room). 011 (sic) call	ote dated 1/12/19 at 5:10 p.m. nurse practitioner) notified of and refusing care, order sident to ER (emergency ed to transport resident, responsible party), no answer						
	_	nable to find documentation in at bed hold information was dent and resident						
	The departmental n	ote dated 1/18/19 at 7:46 p.m.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	1	STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	JMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 625	read, "Called( order given to send to number called mailbot transport resident to e (vital signs) 149/96-9: sat (saturation)."  The surveyor was unathe clinical record that provided to the reside representative.  The departmental not a.m. read in part, "Datalking with case work (name of hospital omeval (evaluation), NP contacted, gave orde hospital notified, daug of nursing) aware. Remedical services) transportal."  The surveyor was unathe clinical record that provided to the reside representative.  The departmental not read in part, "late entit (resident) transferring stand lift redt let go of up held up by staff readt to w/c (wheelchared to go to er (emergence (nurse practitioner) are redt to er, ems (emergence).	name of medical staff), o er for eval (evaluation). RP ox full. 911 called to er (emergency room). VS 2-18-98, unable to obtain O2  able to find documentation in t bed hold information was ent and resident  the dated 1/20/19 at 11:41 ughter states she has been ker wants father sent to itted) for psych (psychiatric) (nurse practitioner) or to send resident to ER, other aware. DON (director REMS (local emergency ensported resident to  able to find documentation in t bed hold information was	F6	525			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION		
F 625	nurse at hospital."  The surveyor was ur	ne 32  ed fair, report called to er  nable to find documentation in at bed hold information was	F 625	5			
	The surveyor informed 3/1/19 at 4:09 p.m. holds were not offered had bed available.	and resident representative.  ed the administrator on  The administrator stated bed  ed as the facility generally					
	part of the Standard Agreement on 2/28/2 Policy" read "Name of the hospital today. If and is admitted to the does not pay to hold Whatever the reside the nursing home is the resident is in the	nt's payment source, unless paid to reserve the bed while hospital, the nursing home					
	However, even if the hold the bed, the res return as soon as a l semi-private room in as the resident still n by this nursing home	this nursing home as long needs the services provided to (and, if the resident is on is eligible for Medicaid					
	to the first available when the resident is the resident has the home's decision to the Assistance Services	does not readmit the resident bed in a semi-private room ready to leave the hospital, right to: appeal the nursing ne Department of Medical, Appeals Division and file a ffice of Licensure and					

PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B. WING		C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 314 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	director of nursing, the nursing, the corporator regional executive and (minimum data set) reconcern on 3/5/19 at the No further information exit conference on 3/4. The facility staff fainformation to Resider representative when to the hospital 9/16/1 3/2/19.  The clinical record of 2/26/19 through 3/5/1 admitted to the facility 1/4/19 with diagnoses to Huntington's disea Parkinson's disease, muscle weakness, dypsychosis not due to physical condition, we post-traumatic stress disorientation, anxiety disorder, altered men cycle metabolism, de classified elsewhere disturbances, hepatic Resident #74's 14-data.	ed the administrator, the le assistant director of le registered nurse, the le dithe regional MDS legistered nurse of the above 4:26 p.m.  In was provided prior to the 5/19.  In was provided bed hold lent #74 and to the resident the resident was transferred 8, 12/9/18, 1/1/19, and  Resident #74 was reviewed 19. Resident #74 was y 3/1/18 and readmitted is that included but not limited se, neglected elder, urinary tract infection, rephagia, unspecified a substance or known leakness, hypertension, disorder, ataxia, y, unspecified mood lital status, disorder of ureal mentia in other disease	F	625			
	BIMS (brief interview	essed the resident with a for mental status) as 3/15. ce of delirium, no behaviors					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP C 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	ODE	00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIA		
F 625	The departmental not p.m. read in part "At (temperature) of 102 was attempted to do success. Appears to made aware and we hospital."  The surveyor was ur in the clinical record representative were bed holds.  The departmental not p.m. read "Resident laceration to back of (amount) bleeding, or called sent to ER (er (evaluation), RP (restant) Ambulance here to to the clinical record representative were bed holds.  The departmental not read in part "Resider weakness T (temper (respirations) 20 bp (sao2 (oxygen satural received order to tradue to resident havir feeling well and hurtinotify [RP (resomitted], message less to do success.	no evidence of psychosis.  Interpretation of the dated 9/16/18 at 12:53 It is time he has a temp It is 1:39 p.m. Several times It is	F	525			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	ULTIPLE CONSTRUCTION  LDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			1	C / <b>05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			103/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 625		e 35 n call from RP received	F 6	625				
		nt had high fever and was						
	in the clinical record t	able to locate documentation hat the resident and resident provided information about						
	read "Called to resider resident fell out of be Reddened area noted head. MD (medical of to send to ER (emergical (evaluation). PEARL light), grips equal. Al (responsible party) hew/c (wheelchair) proproom. No distress not here to transport resident out of w/c by himself	d with raised area to top of loctor) notified, order given gency room) for eval (pupils equal and reactive to ert. Spoke with RP is aware. Resident up in belling self to dinning (sic) oted. 6:04 p.m. Ambulance dent to ER. Resident got up and sat on stretcher."						
	in the clinical record t	able to locate documentation hat the resident orovided information about						
	director of nursing, th nursing, the corporate regional executive an (minimum data set) re concern on 3/5/19 at No further information exit conference on 3/	egistered nurse of the above 4:26 p.m. n was provided prior to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C <b>03/05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 625	F 625 Continued From page 36 information to Resident #101 and the resident		F 6	25		
	to the hospital on 2/					
	was admitted to the readmitted 2/15/19 v	ough 3/5/19. Resident #101				
	behavioral disturban hypothyroidism, seiz muscle weakness, d	mes, dementia without ces, Vitamin deficiency, ures, difficulty in walking, ysphagia, encephalopathy,				
	hypertension, fever, peripheral autonomic	se, stage 2, hyperlipidemia, edema, insomnia, idiopathic neuropathy, type 2 diabetes disease, repeated falls, and hypoglycemia.				
	(MDS) assessment of reference date (ARD resident with a BIMS status) as 11. No as	nission minimum data set with an assessment of 2/7/19 assessed the f (brief interview for mental sessed signs or symptoms of affecting others or psychosis.				
	read "This nurse spo hospital) ER (emergi Resident #101 was a	ote dated 2/14/19 at 5:05 p.m. oke with (name omitted and ency room) she reported that admitted to room (number atic hypotension. Wife aware				
	in the clinical record	nable to locate documentation that the resident and resident provided information about				
	The surveyor interview	ewed the director of nursing				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		MPLETED
		495417	B. WING		,	C 03/05/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		33/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 625	sent with residents whospital. The DON status, pertinent labs sheets, care plan. Tholds were offered to resident representat was not knowledged doesn't address that The surveyor intervice 2/28/19 at 4:20 p.m. know anything about The surveyor intervice (licensed practical new 143) on 2/28/19 at 4:25 sent with residents whospital. Both states The administrator was with the facility not of to the resident and the 3/1/19 at 3:20 p.m. resident and family a about bed holds on a routinely doing bed if the hospital. The surveyor review part of the Standard Agreement on 2/28/Policy" read "Name the hospital today. If and is admitted to the does not pay to hold Whatever the resident.	4:01 p.m. on information when transported to the stated face sheet, code pratory test results, transfer the DON was asked if bed to the resident and the live. The DON stated she ble about that but nursing the wed Resident #101's wife on the wife stated she didn't to bed holds.  Ewed two staff nurses burse #5 and registered nurse to p.m. about information when transported to the did bed holds were not offered.  Eas informed of the concern ffering bed hold information the resident representative on the administrator stated the lare provided information admission but are not hold offers when sent out to riveyor requested the facility with the lare in the lare i	F 6.	25		

PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE  14 NORTH MAIN STREET  RURAL RETREAT, VA 24368		00.2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	may move someone of However, even if the hold the bed, the resireturn as soon as a beami-private room in as the resident still not by this nursing home Medicaid, he or she is nursing home service. If the nursing home d to the first available be when the resident is rethe resident has the rehome's decision to the	hospital, the nursing home else into the resident's room. nursing home is not paid to dent may have the right to ed is available in a this nursing home as long eeds the services provided (and, if the resident is on a eligible for Medicaid es).  oes not readmit the resident as each of the ed in a semi-private room ready to leave the hospital, ight to: appeal the nursing e Department of Medical Appeals Division and file a	F	625			
F 656 SS=D	director of nursing, th nursing, the corporate regional executive an (minimum data set) re concern on 3/5/19 at No further information exit conference on 3/5 Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res	egistered nurse of the above 4:26 p.m.  n was provided prior to the 5/19.  Comprehensive Care Plan  ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and	F	656			4/19/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILD	_		١ ,	c
		495417	B. WING				05/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT RURAL	RETREAT		5	14 NORTH MAIN STREET		
0,	10111 2702 711 1101012	112711		R	RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclutreatment under §483 (iii) Any specialized serehabilitative services provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident' community was assellocal contact agencies entities, for this purpor (C) Discharge plans plan, as appropriate, requirements set fort section.  This REQUIREMENT by:	ames to meet a resident's dimental and psychosocial fied in the comprehensive imprehensive care plan must grane to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will find FASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the titive(s)-als for admission and reference and potential for collities must document is desire to return to the essed and any referrals to the sand/or other appropriate one. In the comprehensive care in accordance with the thin paragraph (c) of this	F	656			
	review, the facility sta	riew and clinical record aff failed to develop a care eted behaviors for 1 of 28			Resident #101 no longer resides in the facility.	•	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C	
NAME OF D		493417	B. WING	CTDEET ADDRESS CITY STATE 7ID CO	•	3/05/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
CARRING	TON PLACE AT RUR	AL RETREAT		514 NORTH MAIN STREET			
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From p	age 40	F 65	56			
	residents (Resider	nt #101).		A review has been conducte	ed by the		
	,	,		Director of Nursing/Designe	-		
	The facility staff fa	iled to develop a care plan to		plans for current residents to			
		nacological interventions prior to		residents with physician ord	ers for		
	the use of Haldol (	an antipsychotic medication)		psychotropic medications ha	ave		
	and Zoloft (an anti	depressant) for Resident #101.		non-pharmacological interve	entions as well		
				as person centered targeted			
		of Resident #101 was		identified on the care plan p	rior to use of		
		through 3/5/19. Resident #101		such meds.			
		e facility 1/31/19 and					
		9 with diagnosis that included		Education has been provide	d to licensed		
		altered mental status, abnormal		nurses by the Director of	04/40/40		
		zymes, dementia without		Nursing/Designee 04/17/19, 04/19/19 regarding appropri			
		ances, Vitamin deficiency, eizures, difficulty in walking,		accurate update of the care			
		, dysphagia, encephalopathy,		residents with physician □s of	-		
		ease, stage 2, hyperlipidemia,		psychotropic medications to			
		er, edema, insomnia, idiopathic		the care plan reflects	0.104.0 4.144		
		nic neuropathy, type 2 diabetes		non-pharmacological interve	entions as well		
	'	n's disease, repeated falls,		as person-centered targeted			
	frequent micturition	n, and hypoglycemia.		be utilized prior to use of psymedications. A care plan rev			
	Resident #101's a	dmission minimum data set		conducted for three (3) resid	lents weekly		
	(MDS) assessmen	nt with an assessment		for three (3) months to ensu	re that		
		RD) of 2/7/19 assessed the		residents with orders for psy	•		
		AS (brief interview for mental		medications have their care			
	l '	assessed signs or symptoms of		to reflect non-pharmacologic			
	delirium, behaviors	s affecting others or psychosis.		interventions to be utilized p			
				of psychotropic medications			
		rehensive care plan dated		person-centered targeted be	enaviors to be		
		ne problem onset that read "I		monitored.			
		effects r/t (related to) my		The results of the interviews	and rovious		
		(medication) use. I take Zoloft depression. Interventions:		The results of the interviews will be discussed by the Dire			
	Monitor and docur	•		Nursing/Designee monthly for			
	וייטווונטו מווע עטכעו	Hent Deliaviors.		months at the Quality Assura			
	A care plan was n	ot developed for behaviors to		Performance Improvement (			
		nacological interventions and		Meeting (QAPI). The interdis			
		argeted behaviors for the use of		team (IDT) will make recomi			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _				C / <b>05/2019</b>
	ROVIDER OR SUPPLIER	RETREAT		51	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET URAL RETREAT, VA 24368	1 00	100/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	by mouth on 2/16/19 mg po on 2/17/19 at The information was detail notes. The cli documentation of int use of Haldol each to the use of Haldol and The surveyor review "Behavioral Assessin Monitoring" on 3/1/1 "Management:  2. The care plan will comprehensive asses with current standard 7. Interventions will I an overall care envirophysical, functional a strives to understand resident's distress on 8. Interventions and a detailed assessment and behavioral symplectic care plan will include description of the best control of the best care plan will include description of the best care plan will include description of the best care plan will include description of the best care plan will include the properties of the propertie	ved Haldol 2 mg (milligrams) of at 8:54 p.m. and Haldol 2 6:41 a.m. for yelling out. located in the February 2019 inical record did not have erventions utilized prior to the me or identified behaviors for d Zoloft.  ed the facility policy titled ment, Intervention, and 9. The policy read in part incorporate findings from the essment and be consistent ds of care. De individualized and part of conment that supports and psychosocial needs, and d, prevent or relieve the r loss of abilities. approaches will be based on ent of physical, psychological botoms and their underlying me potential situational and ens for the behavior. The ens, at a minimum: a. a havioral symptoms including duration, outcomes, location,	F6	656	for revisions as indicated necessary to sustain substantial compliance.		
	behavioral and/or ps rationale for the inter Specific and measur behaviors. e. How the effectiveness of the	ualized interventions for the cychosocial symptoms. c. The evention and approaches. d. cable goals for targeted he staff will monitor for intervention.					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 656	of antipsychotic medic behavioral symptoms 10. When medication behavioral symptoms rationale for use, pote the behavior, other aptried prior to the use opotential risks and be discussed with the restarget behaviors and dosage, duration, mo adverse consequence dose reduction.  The surveyor informed director of nursing, the nursing, and the corpabove concern on 3/1.  No further information exit conference on 3/2.  Care Plan Timing and CFR(s): 483.21(b)(2)(2)(2)(2)(4)(4)(2)(2)(4)(4)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	to avoid or reduce the use cations to manage s. s are prescribed for s, documentation will include ential underlying causes of opproaches and interventions of antipsychotic medications, enefits of medications as sident and/or family, specific expected outcomes, enitoring for efficacy and es, and plans for gradual and the administrator, the e assistant director of orate registered nurse of the 1/19 at 5:34 p.m.  In was provided prior to the 5/19. If Revision (i)-(iii)  Pensive Care Plans orehensive care plan must or days after completion of sessesment. Iterdisciplinary team, that inted to-cysician.		656		4/19/19	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	E SURVEY MPLETED
		495417	B. WING			C 2/05/2040
NAME OF DE	ROVIDER OR SUPPLIER	400417		STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2019
NAME OF F	NOVIDER OR SUFFLIER				-	
CARRING	TON PLACE AT RURAL	RETREAT		514 NORTH MAIN STREET		
				RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	7 Continued From page 43		F 6	57		
	(E) To the extent prathe resident and the An explanation must medical record if the and their resident renot practicable for thresident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii)Reviewed and reviteam after each assessments. This REQUIREMENT by:  Based on staff interreview, and clinical resident and the review, and clinical resident.	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined e development of the estaff or professionals in nined by the resident's needs he resident. Vised by the interdisciplinary resident, including both the quarterly review  T is not met as evidenced view, facility document ecord review, the facility staff		Resident #362 no longer resident #11, the c	are plan has	
	T	revise the current plan for 5 of 28 residents ident #11, Resident #3,		been updated/revised by the E Nursing/Designee to include person-centered targeted beha		
	Resident #19, and R			well as non-pharmacological in specific to the use of psychotro	nterventions	
	The findings included	d:		medications. Resident #3 has care plan updated/revised by t		
	current comprehensi			of Nursing/Designee to include person-centered targeted behavell as non-pharmacological in to be utilized prior to use of ps medications. Resident #19 has care plan updated/revised by the process of th	aviors as nterventions ychotropic s had her	
	was admitted to the diagnoses that include fibula fracture, head 2 diabetes mellitus, udisorder, muscle wes	ough 3/5/19. Resident #362		of Nursing/Designee to include person-centered targeted behavell as non-pharmacological in to be utilized prior to use of ps medications. Resident #15 has care plan updated/revised by to f Nursing/Designee to include person-centered targeted behaveled.	e specific aviors as nterventions ychotropic s had her the Director e specific	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From pag	e 44	F 6	57		
	ischemic attacks), hy	disease, TIA (transient rperlipidemia, intervertebral lumbosacral region, and		well as non-pharmacological in to be utilized prior to use of psy medications.		
	The admission minimum data set (MDS) assessment had not yet been completed.  The February 2019 physician orders were reviewed. Resident #362 was ordered Zoloft 100 mg (milligrams) one by mouth daily and Norco 5-325 tablet take one by mouth every 4 hours as needed for pain.			A review has been conducted to Director of Nursing/Designee or plans for current residents to en	f care nsure that	
				residents with physician orders psychotropic medications have non-pharmacological interventi as person centered targeted be identified on the care plan prior such meds.	ons as well ehaviors	
	care plan read, "I have anxiety/depression." behaviors. There we behaviors or non-phadocumented.  The current comprehe 2/21/19 read "I have secondary to physica There were no identi	plan dated 2/21/19. The		Education has been provided to nurses by the Director of Nursing/Designee 04/17/19, 04 04/19/19 regarding appropriate accurate update of the care plaresidents with physician sording psychotropic medications to enthe care plan reflects non-pharmacological intervential as person-centered targeted be be utilized prior to use of psychomedications. A care plan review conducted for three (3) residen	a./18/19 and e and an for ers for esure that ons as well ehaviors to notropic w will be	
	The current comprehensive care plan dated 2/21/19 read "I am at risk for side effects r/t (related to) psychotropic med (medication) use. I take Zoloft for a diagnosis of schizophrenia, bipolar disorder, anxiety and depression." Interventions: Monitor and document behaviors qshift (every shift). Side effects of medications were documented but there were no targeted behaviors or non-pharmacological interventions			for three (3) months to ensure a residents with orders for psychomedications have their care plate to reflect non-pharmacological interventions to be utilized prior of psychotropic medications as person-centered targeted behamonitored.	that otropic an updated r to the use well as	
	identified.	ensive care plan dated		The results of the interviews ar will be discussed by the Directon Nursing/Designee monthly for the control of	or of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STAT 514 NORTH MAIN STREET RURAL RETREAT, VA 243		00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 657	to) my recent fracture degenerative disc discare plan did not have approaches for pain documented. The carencourage coping management."  The surveyor informed director of nursing (Director of nursing (Director of nursing (Director of nursing of the above p.m. The DON was know what behaviors Zoloft. The DON stare was not specific for Zoloft and they can choose from psychological symptomassessing prior to accomply the proposition of the surveyor request management and psychological symptomasses and the proposition."	experience pain r/t (related e. I also have a diagnosis of sease, and chronic pain." The re non-pharmacological management identified or are plan read "Identify and echanisms r/t pain  ed the administrator, the DON), the corporate defined the assistant director of concern on 2/27/19 at 3:04 asked how does the staff are being targeted for ted that behavior monitoring coloft; it's for the entire shift. It's for the entire shift on the full array of the poon the poon the poon the full array of the poon the poon the poon the full array of the poon th	F		y Assurance ement Committee interdisciplinary recommendations ated necessary to	
	"Behavioral Assessm Monitoring" on 3/1/19 "Management: 2. The care plan will comprehensive asse with current standard 7. Interventions will be an overall care envir physical, functional as	nent, Intervention, and  9. The policy read in part  incorporate findings from the ssment and be consistent				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657		r loss of abilities. I approaches will be based on	F 6	57		
	a detailed assessment and behavioral symple causes, as well as the environmental reason care plan will include description of the befrequency, intensity, environment, and proposed and individe behavioral and/or perationale for the interest specific and measure behaviors. e. How the effectiveness of the g. Non-pharmacology to the extent possible of antipsychotic medication behavioral symptom 10. When medication behavioral symptom rationale for use, pothe behavior, other attried prior to the use potential risks and between the symptoment of the symptoment of the use potential risks and between the symptoment of the use potential risks and the symptoment of the use potential risks and the s	ent of physical, psychological of the potential situational and one for the behavior. The a, as a minimum: a. a chavioral symptoms including duration, outcomes, location, ecipitating factors. b. ualized interventions for the sychosocial symptoms. c. The revention and approaches. d. rable goals for targeted he staff will monitor for intervention. gic approaches will be utilized e to avoid or reduce the use dications to manage s.  Ins are prescribed for s, documentation will include tential underlying causes of approaches and interventions of antipsychotic medications, enefits of medications as				
	target behaviors and dosage, duration, m adverse consequent dose reduction.  The surveyor review "Pain-Clinical Protoc physician and staff whave pain or who are The physician will or non-pharmacologic."	esident and/or family, specific dexpected outcomes, onitoring for efficacy and ces, and plans for gradual red the facility policy titled col." The policy read "1. The will identify individuals who e at risk for having pain. 2. reder appropriate and medication interventions dual's pain. 3. Staff will				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
		495417	B. WING		0.5	C 3/ <b>05/2019</b>
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 0.	310312013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 657	appropriate physical interventions: for ex repositioning, massatalk about chronic parabolic exit conference on 3  2. The facility staff four comprehens targeted specific bet psychotropic medication-pharmacological mon-pharmacological staff four comprehens targeted specific bet psychotropic medication-pharmacological staff four comprehens targeted specific bet psychotropic medication-pharmacological staff four comprehens targeted specific bet psychotropic medication-pharmacological staff four comprehens and staff four comprehens targeted specific bet psychotropic medical record of 2/26/19 through 3/5/admitted to the facility 7/14/18 with diagnost limited to acute respiction crespiratory for metabolic encephalom successive disorder, polyneuropathy, hypreflux disease, adult schizoaffective disorder, polyneuropathy, hypreflux disease, adult schizoaffective disorder, polyneuropathy, hypreflux disease, adult schizoaffective disorder, polyneuropathy, hypreflux disease, urinary traction obstructive pulmonal deficiency.  Resident #11's quantity quantity for the properties of the prope	s of a comforting and and complementary ample, local heat or ice, age, and the opportunity to ain."  on was provided prior to the //5/19.  ailed to review and revise the ive care plan to include naviors for the use of ations and all interventions for Resident  f Resident #11 was reviewed 19. Resident #11 was ty 2/4/15 and readmitted sees that included but not irratory failure with hypoxia, ailure with hypercapnia, opathy, difficulty in walking, cute kidney failure, chronic 2 diabetes mellitus, y, hypothyroidism, major bipolar disorder, okalemia, gastro-esophageal failure to thrive, der, urethral stricture, constipation, Parkinson's tinfection, chronic ry disease, and Vitamin	F 69	57		
	(ARD) of 2/13/19 as	assessment reference date sessed the resident with a for mental status) as 15.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	<u> </u>	1 03/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	delirium, behaviors at The February 2019 previewed. Resident # 7.5 mg (milligrams) b day), Effexor XR 75 m Trazodone 100 mg by Geodon 20 mg by mo Valproic acid 250 mg Resident #11's currer dated 8/29/18 docum as a problem. Approato my physician any tracould be associated administer my medical physician and implemeducate me and/or mrisks/benefits of psychme for effectiveness of monitor me for changed dose may need reducincreasing, communic pharmacy/interdiscipl recommendations to evaluate me on a perdose reduction or discontinuous to the current comprehed address targeted behaviors identified of dated 8/29/18 read, "disrupting behaviors of and wheels off."	sed signs or symptoms of fecting others or psychosis.  hysician's orders were that had orders for Buspirone of mouth tid (three times a ring daily for depression, or mouth daily at bedtime, buth bid (twice a day), and twice a day.  It comprehensive care plan ented psychotropic drug use aches checked were report roublesome symptoms that with use of the drug, ations as prescribed by the lent behavioral interventions, or family on potential notropic drug use, monitor of psychotropic drug use, es that may suggest my stion, discontinuation, or cate changes and any inary team me and my physician, iodic basis for a gradual continuation, if applicable.  ensive care plan did not aviors for Buspar, Geodon, and Valproic acid or identify	F 6	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	I	03/05/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	dated 12/3/18 read in schizoaffective disord Depakote for mood seval (evaluation) for gof Depakote 250 mg (medication) adjustm 37.5 mg added on 9/depression, today, padepression, r/t (relate grandson is facing, stable. Recommend to 50 mg qd and do repeakote while adjusting no targeted behavior note other than situal. The psychiatric nursed dated 12/27/18 read depressive symptom increased Effexor to today she reports mile been sad past few dedeceased. She contand finds it helpful, Distability and trazodor patient has remained current comprehensiany of these concerns. The psychiatric nursed dated 1/16/19 read in bipolar moods with mr.5 mg tid has failed increase in anxiety. Edoing ok now, and slicomprehensive care these concerns.	n part "Patient with der, on Geodon and tability, pharmacy request gdr (gradual dose reduction) bid, patient with med ents for depression, Effexor 24/18 for reports of atient reports feeling more ed to) bad situation her the reports moods feel ation was to increase Effexor not recommend GDR for esting Effexor." There were so identified in the progress tional with grandson.  The practitioner progress note in part "Patient with so per her report, last visit XR75 mg qd (every day), do improvement, but has any sas her cousin recently inues on buspar for anxiety repakote Geodon for mood the for insomnia. Staff report to overall at baseline." The ever care plan did not identify	F 65	7			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	Continued From page	ge 50	F 6	57			
F 007	director of nursing, to nursing, the corporate MDS (mir registered nurse, and the above concerns). The surveyor reques psychotropic medical. The surveyor review "Behavioral Assessimential Monitoring" on 3/1/1 "Management:  2. The care plan will comprehensive assess with current standar 7. Interventions will an overall care environment strives to understand resident's distress of 8. Interventions and a detailed assessment and behavioral symbological care plan will included description of the before quency, intensity environment, and province and the province of the interventional for the int	the assistant director of the registered nurse, the himum data set) assessment and the regional executive of on 3/5/19 at 4:26 p.m.  Sted the facility policy on ations.  Wed the facility policy titled ment, Intervention, and 19. The policy read in part of ronment that supports and psychosocial needs, and d, prevent or relieve the or loss of abilities. If approaches will be based on the potential situational and their underlying the potential situational and the potential situational and the potential situational and the potential symptoms including the duration, outcomes, location, recipitating factors. b. Intervention and approaches. d.	F 6	57			
	behaviors. e. How the effectiveness of the 9. Non-pharmacolog to the extent possib	rable goals for targeted he staff will monitor for intervention. gic approaches will be utilized le to avoid or reduce the use dications to manage					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1	33/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPI  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	rationale for use, pot the behavior, other a tried prior to the use potential risks and be discussed with the retarget behaviors and dosage, duration, madverse consequent dose reduction.  No further information exit conference on 3.  3. The facility staff far Resident #3's current include specific target psychotropic medical psychotropic medic	ns are prescribed for s, documentation will include ential underlying causes of ipproaches and interventions of antipsychotic medications, enefits of medications as esident and/or family, specific expected outcomes, onitoring for efficacy and ess, and plans for gradual on was provided prior to the 1/5/19.  Iiled to review and revise to comprehensive care plan to eted behaviors for the use of tions and and interventions for tions.  If Resident #3 was reviewed the state included but not limited with hypoxia and the selegs syndrome, diastolic brillation, obstructive sleep, constipation, idiopathic thy, gastro-esophageal reflux mia, hypothyroidism, major insomnia, anxiety, chronic min D deficiency, benign morbid obesity, hypertension, oulmonary disease, type 2	F 6	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 03	103/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 52	F 6	57		
	assessment with an a (ARD) of 2/6/19 asse BIMS (brief interview evidence of delirium, psychosis.	•				
	was at risk for side ef medications-antidepro (diagnosis) includes of	plan dated 2/20/19. care plan that read resident				
		able to locate specific r psychotropic medication logical interventions.				
	director of nursing, th nursing, the corporate corporate MDS (minir registered nurse, and the above concerns of					
	psychotropic medicat	ed the facility policy on ions.				
	"Behavioral Assessm	ed the facility policy titled ent, Intervention, and . The policy read in part				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		1 03/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	comprehensive asses with current standard. 7. Interventions will be an overall care environmental functional a strives to understand resident's distress or 8. Interventions and a detailed assessme and behavioral sympocauses, as well as the environmental reaso care plan will include description of the befrequency, intensity, environment, and preactionale for the interspecific and measur behavioral and/or pserationale for the interspecific and measur behaviors. e. How the effectiveness of the infectiveness of	incorporate findings from the sament and be consistent as of care. The individualized and part of comment that supports and psychosocial needs, and approaches will be based on ant of physical, psychological atoms and their underlying approaches will be based on ant of physical, psychological atoms and their underlying approaches will be based on a for the behavior. The approaches a manimum: a. a approaches and approaches. b. In the properties of the vention and approaches. In the vention and approaches. In the vention and approaches are staff will monitor for an approaches will be utilized as to avoid or reduce the use incations to manage as are prescribed for an approaches and interventions of antipsychotic medications, and approaches and interventions of antipsychotic medications as assident and/or family, specific	F 6	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495417	B. WING		03/05/2019	
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368		
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F 657	Continued From page	ge 54	F 65	7		
	No further information	on was provided prior to the 3/5/19.				
	current comprehens targeted behaviors interventions when were ordered and a The clinical record of 2/26/19 through 3/5 admitted to the facil 1/19/19 with diagno limited to methicillin	ailed to review and revise the sive care plan to include and non-pharmacological psychotropic medications dministered to Resident #19.  of Resident #19 was reviewed /19. Resident #19 was ity 11/30/18 and readmitted ses that included but not resistant staphylococcus evated white blood count, and				
	assessment with an (ARD) of 1/22/19 as BIMS (brief interview There were no assedelirium, behaviors  The February 2019 #19 were reviewed. Sertraline 100 mg (in the service of the service	ay minimum data set (MDS) a assessment reference date assessed the resident with a w for mental status) as 13/15. assed signs or symptoms of affecting others or psychosis.  physician orders for Resident Resident #19 had orders for milligrams) 1 and ½ tablet ne 50 mg at bedtime.				
	dated 12/11/18 for p were no targeted be non-pharmacologica antidepressants pre Amitriptyline). Resi that read resident w confusion secondar	ent comprehensive care plan osychotropic drug use. There ehaviors identified or al interventions for the escribed (Sertraline and dent #19 also had a care plan was at risk for increasing y to auditory hallucinations.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495417	B. WING		03/05/2019		
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 657	director of nursing, anursing, the corporate MDS (mir registered nurse, are the above concerns). The surveyor requestive psychotropic medical The surveyor review "Behavioral Assessi Monitoring" on 3/1/1 "Management:  2. The care plan will comprehensive assivith current standar 7. Interventions will an overall care enviphysical, functional strives to understan resident's distress of 8. Interventions and a detailed assessment behavioral symmatical care plan will includ description of the befrequency, intensity environment, and put Targeted and individes	need the administrator, the the assistant director of atte registered nurse, the nimum data set) assessment at the regional executive of on 3/5/19 at 4:26 p.m.  sted the facility policy on ations.  Wed the facility policy titled ment, Intervention, and 19. The policy read in part  I incorporate findings from the essment and be consistent ds of care.  be individualized and part of ronment that supports and psychosocial needs, and d, prevent or relieve the or loss of abilities.  d approaches will be based on ent of physical, psychological ptoms and their underlying the potential situational and ons for the behavior. The e, as a minimum: a. a ehavioral symptoms including the duration, outcomes, location, recipitating factors. b. dualized interventions for the	F 65	7			
	rationale for the inte Specific and measu	sychosocial symptoms. c. The evention and approaches. d. rable goals for targeted he staff will monitor for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	5/2019	
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F 657	to the extent possible of antipsychotic med behavioral symptom 10. When medication behavioral symptom rationale for use, pothe behavior, other a tried prior to the use potential risks and be discussed with their target behaviors and dosage, duration, madverse consequent dose reduction.  No further information exit conference on 35. For Resident #15 plan did not address infections, drug resist contact precautions.  Resident #15 was a 11/22/15 and readmincluded heart failured disease, psychotic of tract infection (UTI), disturbance, dysphaweakness, and difficing quarterly minimum of assessment referent scored 3/15 on the bestatus and was assessment symptom.	gic approaches will be utilized to avoid or reduce the use dications to manage as.  Ins are prescribed for as, documentation will include tential underlying causes of approaches and interventions of antipsychotic medications, enefits of medications as esident and/or family, specific dexpected outcomes, onitoring for efficacy and ces, and plans for gradual on was provided prior to the arecurring urinary tract stant infections, or orders for dimitted to the facility on itted on 11/18/18. Diagnoses as, hypertension, Alzheimer's disorder, pneumonia, urinary dementia with behavior agia, anxiety, muscle culty walking. On the data set assessment with ce date 11/15/18, the resident orief interview for mental assed as without symptoms of or behaviors affecting care.	F 65	57			
	ambulated and used assistance, was free	licated the resident If the toilet with 1-2 person Quently, but not always, Reprompted toileting program.					

PRINTED: 05/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIES  CARRINGTON PLACE AT RU			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2010
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
treated for urinar November 2018 2019. There wer culture and sens precautions were urinary tract infect resident's care prinfections.  The administration ontified of the coon 3/4/19.  Services Provides CFR(s): 483.21(b)(3) Coonstruct The services provided by the must- (i) Meet profession This REQUIREM by: Based on staff in and facility document follow profession medication account and in all of their (Resident #89, 9)  The findings included the resident #89. Resident #89 was re	view revealed a the resident was a tract infections on admission in and in January and February re orders for urinalysis with tivity on 1/24 and 2/15. Contact reordered for antibiotic resistant retion in February 2019. The an did not address urinary tract and director of nursing were recent during a summary meeting and Meet Professional Standards of (3)(i)  Imprehensive Care Plans and the facility, recomprehensive care plan, and standards of quality. ENT is not met as evidenced anterview, clinical record review, ment review, facility staff failed to all standards of practice for untability for 6 of 28 residents medication cart narcotic logs. 1, 72, 79, 36, 3 and 72).	F 6	57	et for ger or e effect ed arcotic lee has and eeded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495417	B. WING			l	05/2019
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				51	14 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		R	URAL RETREAT, VA 24368		
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	<u> </u>		1	1	,		
F 658	failure. On the admis Set) with an ARD (As of 2/1/19, the resider extensive assistance dressing and persona	pressure and respiratory ssion MDS (Minimum Data ssessment Reference Date) at was coded as requiring of 2 staff members for al hygiene. Resident #89	F	658	notified for Lantus and accuchecks obtained/administered 1-3 hours after meals and at bedtime in January and February 2019. There was no adverse effect to the resident. Regarding the narcotic count sheets for current medication carts, the Director of		
	was also coded as being totally dependent on 2 staff members for bathing.  On 2/28/19 at approximately 9:30 am, the surveyor went into Resident #89's room to conduct a resident interview. During this time, the resident was observed to be using Oxygen at 2 liters/minute by nasal cannula.				Nursing/Designee has provided educat to licensed nurses regarding signing th narcotic log attesting that the count in accurate at the beginning and end of eshift. For Resident #3, a late entry/addendum has been made to refl the resident srefusal of the Lasix on 2/27/2019 at 11:17am by the Director of	e ach ect	
	corporate MDS nurse room. They were me as physical therapy wheelchair. The resi wearing oxygen. The surveyor reviewe Resident #89. During could not find a physical administration of oxygen notes since admission had documented that	am, the surveyor and the e went into the resident's et in the doorway of the room was taking him to therapy in a dent was observed to be ed the clinical record of g this review, the surveyor ician order for the gen. However, in the nurses' en on 1/26/19, the facility staff t Resident #89 was receiving nute by nasal cannula.			Nursing/Designee. The physician and responsible party have been notified regarding the resident □s refusal of the medication and notification has been documented in the medical record. For resident #72, the physician and the responsible party have been notified regarding the medication variance in which Algera cream was not administer as ordered on 2/27/19. There was no adverse effect to the resident. The Licensed nurse was provided with education by the Director of Nursing/Designee regarding only signing	red	
	the above documents pm in the conference the director of nursing	the facility's policy on gen.			that meds, creams, treatments have be administered immediately after administration and not before.  A review has been conducted by the Director of Nursing/Designee for the previous thirty (30) days for the following areas:  (A) Residents that currently utilize/requived oxygen will have their physician sorder.	een ng uire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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NAME OF D	ROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019		
NAME OF FI	NOVIDER OR SUFFLIER								
CARRING	TON PLACE AT RURAL	RETREAT			14 NORTH MAIN STREET				
				K	RURAL RETREAT, VA 24368				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 59	F 6	558					
	"Oxygen Administratic "Verify that there is procedure"  At 11 am, LPN (licens	sopy of the facility's policy for on". The policy read in part, a physician order for this sed practical nurse) #1 that he resident's care on 3/5/19			reviewed to ensure that there is a physician sorder for the oxygen.  (B) Residents with physician sorders insulin, accuchecks, and dialysis will have their EMAR reviewed to ensure that accuchecks are being performed and insulin is administered per the				
	was interviewed in the surveyor. The survey needed to obtain a ph	e conference room by the or asked LPN #1 if you nysician order before			physician⊡s order and documented appropriately. (C) Narcotic logs will be reviewed for t				
	do. But I assumed th without checking on the				previous thirty (30) days by the Director Nursing/Designee. Observations will be completed by the Director of Nursing/Designee at shift change to				
	At approximately 1:30 interviewed the doctoresidents care. The contract of the	r responible for this			ensure that narcotic count is conducted the log is signed by both nurses and controlled medication are accounted for				
	"There is not an order	d progress notes and stated r for the resident to be given d this when they admitted			Additionally, medication administration observation will be conducted with curl licensed nurses to ensure that controlled	ent			
	him from the hospital.				medications including pain medication signed out on the narcotic inventory sh	is			
	At 4:20 pm, the surve administrative team of indings.	yor notified the f the above documented			only after the medication is administered not prior and that refused medications documented appropriately, and physicismade aware.	are			
		exit conference on 3/5/19.			(D) Electronic Medication Administrati Records will be compared to physician orders for the previous thirty (30) days	□s			
	orders for the adminis	failed to follow physician stration of insulin and ar checks (Accu checks) for			the Director of Nursing/Designee to identify medications administered and accuchecks performed outside the physician ordered time frame. The revi will also identify whether the physician				
	1/31/19 with the follow limited to anemia, atri	mitted to the facility on wing diagnoses of, but not ial fibrillation, end stage es, heart failure and high he admission MDS			responsible party were notified, and notification documented appropriately. Notifications to physician and responsi party will be made and documented in clinical record as indicated necessary a	ble the			

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIF 514 NORTH MAIN STREET	CODE	00/00/2010	
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		· ·		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From page	e 60	F 6	58			
	Reference Date) date coded as requiring ex	with an ARD (Assessment e of 2/7/19, the resident was ktensive assistance of 2 staff g, and personal hygiene.		the time of the review.  Education has been prov	ided to licensed		
	Resident #91 was also dependent on 2 staff. The surveyor reviewed Resident #91 on 2/26 this review, the surveyor the surveyor the surveyor that the survey of the surveyor that the survey of the surveyor that the surveyor that the surveyor that the survey of the surveyor that the survey or the surveyor that the survey	so coded as being totally members for bathing. ed the clinical record of 6/19 through 3/5/19. During eyor noted the following		nurses by the Director of Nursing/Designee 04/17/ 04/19/19 regarding the fo (A) The physician must la physician □s order mus	19, 04/18/19 and ollowing areas: be contacted, and the obtained		
	bedtime (6:30 am, 11 pm)	three times every day and at :30 am, 4:30 pm and 9:00 units in morning"		prior to the application ar oxygen.  (B) Accuchecks must be medications including Ins administered per the phy cannot be carried out. No documented in the clinical	e performed and sulin must be sician⊡s order otification must be		
	Administration Recor February 2019. Resid facility to dialysis on I Friday. During this re dialysis days the facil detail section of the M insulin that was to be	ed the MAR (Medication d) for Resident #91 for dent #91 goes out of the Monday, Wednesday and view, the surveyor noted on lity staff documented in the MAR for the Accu checks and given at 6:30 am that the		This also includes medical administered late or outsitime frame.  (C) Medications must on documented after they are never before. This including as well. If medications	ations ide the permitted ally be re administered, es the ation inventory s are refused, do		
	Lantus insulin that wa dialysis days were no resident either becau unavailable or gone t			not document as adminis medications cannot be acmust notify physician and party.  (D) Controlled medication must be accounted for by at shift change and the Narcotic/Controlled Medication must be accounted for by at shift change and the Narcotic/Controlled Medication.	dministered, you d responsible ons/Narcotics v two (2) nurses		
	documentation: " "11:24 am 2/2 pm) Accu checks three meals and at bedtime " 11:24am 2/25/19	25/19 (Scheduled 2/5/19 9 ee times every day before		sheet must be signed by shift change. The Director of Nursing/E complete reviews for three per week for three (3) mo following areas to sustain compliance:	Designee will be (3) residents onths for the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495417 B. WING _					C	
NAME OF D	ROVIDER OR SUPPLIER	433417	5:0 -	-	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019	
NAME OF PI	ROVIDER OR SUPPLIER							
CARRING	TON PLACE AT RURAL	. RETREAT			14 NORTH MAIN STREET			
				R	RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From pag	ge 61	F	658				
	meals and at bedtim	e			(A) Three (3) residents that currently			
		9 (Scheduled 4:30 pm			utilize/require oxygen will have their			
		s three times every day			physician sorders reviewed to ensure	ج		
	before meals and at				that there is a physician s order for th			
		9 (Scheduled 6:30 am			oxygen and that the concentrator is se			
		ks three times every day			the physician sordered rate of liter flo			
	before meals and at				(B) Three (3) residents with physician			
		19 (Scheduled 6 pm 2/18/19)			orders for insulin, accuchecks and dial			
	NovalogInject 5 ui	• • •			will have their Electronic Medication	,		
					Administration Record reviewed to ens	sure		
	On 3/1/19 at approxi	imately 1 pm, the surveyor			that accuchecks are being performed a	and		
	asked corporate MD	S nurse what these dates			insulin is administered per the			
	and times meant. The	he corporate MDS nurse			physician □s order and documented			
	stated "The first dates and times are the times				appropriately.			
	the Accu checks and	l insulin were documented as			(C) Narcotic logs/controlled medicatio	n		
	_	or administrated. The dates			count sheet/controlled medication			
		enthesis is the date and time			inventory sheets and controlled			
		nsulin were scheduled to be			medication count will be observed for			
	obtained and/or give	n."			each cart on both wings two (2) time p week for three (3) months to ensure th			
	On 3/5/19 at 4:20 pn	n, the surveyor notified the			controlled medications are signed out			
		of the above documented			after administration, not before; the			
		or showed the corporate			controlled medication/narcotic count sl			
		ation of the above findings.			is signed by both nurses at shift chang			
	•	reviewed this but did not			after controlled med count is performe	d		
		ns regarding this. The			and medications are accounted for.			
	_	OON (director of nursing)			Medication Administration observation	S		
		ard for the nurses' to follow			will be conducted for two (2) licensed			
	_	medications or obtaining			nurses weekly for three (3) months to			
	_	OON stated, "they have an			ensure meds are administered,			
		r the time that these were			accuchecks are performed per the			
		surveyor requested a copy of			physician  sorders. (D) Electronic Medication Administrati	ion		
	the facility's policy or	i documentation.			Records will be compared to the active			
	The surveyor receive	ad the facility's noticy titled			physician sorders for three (3) reside			
		ed the facility's policy titled  Medication Administration"			each week to ensure that accuchecks			
	which read in part ".				performed and insulin is administered			
	•	documented immediately			ordered by the physician. Accuchecks			
	after (never before) i	•			medications including insulin administe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _	B WING		С	
NAME OF D	DOMED OF SUPPLIED	493417	B. WING_	OTDEET ADDRESS SITV S	<u> </u>	03/05/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
CARRING	TON PLACE AT RURA	L RETREAT		514 NORTH MAIN STREET	Т		
				RURAL RETREAT, VA	24368		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		
F 658	Continued From pa	ge 62	F 6	58			
F 658	No further informat surveyor prior to the 3. In the narcotic nurse had signed of to the nurse giving.  Resident #79 was non12/21/18 with the not limited to heart end stage renal distinct the annual MDS (MARD (Assessment coded the resident Interview for Mentatoriew for Mentatoriew for dressing member for dressing The surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500 with LF #2 on 2/27/19 at approximation to the surveyor was mallway 500	ion was provided to the e exit conference on 3/5/19. E log, it was noted that the out for a pain medication prior this to Resident #79.  Teadmitted to the facility e following diagnoses of, but failure, high blood pressure, ease, diabetes and stroke. On linimum Data Set) with an Reference Date) of 1/21/19 as having a BIMS (Brief I Status) score of 15 out of a 5. Resident #79 was also limited assistance of 1 staff ag and personal hygiene. eviewing the narcotic log on PN (licensed practical nurse) proximately 5:20 am. It was dent #79, the log had	F6	outside the physic as well as docume responsible party reviewed. Notifical and responsible party documented in the indicated necessareview.  The results of the will be discussed to Nursing/Designee months at the Qua Performance Imprometing (QAPI). Team (IDT) will ma	tions to the physician arty will be made and e clinical record as ary at the time of the interviews and review by the Director of amonthly for three (3) ality Assurance rovement Committee The interdisciplinary ake recommendations dicated necessary to	/S	
	medication, count at The surveyor asked medication) had be LPN #2 stated, "Not places on this sheet have to do is put the On 3/1/19 at 5:33 padministrative team findings. The surveyof nursing) what was facility that she hold The DON stated, "The surveyor that she hold the DON stated,"	t with a date, name of and signature of the nurse. d LPN #2 if Percocet (pain en administrated to resident. It hasn't, I just sign out all the at before I give it so that all I e time it was given."  Then, the surveyor notified the an of the above documented eyor asked the DON (director as the standard practice in the ds her nurses accountable to. They are suppose to document book after a pain medication is resident."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	33/33/23 13	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 658	Continued From pag	ne 63	F 6	58			
	the facility's policy tit Medication Administ Administration of n documented immedi given"	ately after (never before) it is on was provided to the					
	The facility staf failed to notify the property in the pr	exit conference on 3/5/19.  f failed to The facility staff hysician when Resident #36's ulin were given 1-3 hours ime.					
	8/5/15 with the follow limited to anemia, he pressure, diabetes a quarterly MDS (Minii (Assessment Refere resident was coded Interview of Mental Spossible score of 15 coded as requiring e	dmitted to the facility on ving diagnoses of, but not eart failure, high blood and dementia. On the mum Data Set) with an ARD once Date) of 12/18/18, the as having a BIMS (Brief Status) score of 15 out of a . Resident #36 was also extensive assistance of 2 staffing, personal hygiene and					
	100 unit/ml (milliliter) bedtime" This me given at 9 pm. The substantial January 2019 MAR (Record) along with the nursing notes. Our surveyor noted documents of the MAR to	ohysician order for "Lantus of Administer every night at edication was scheduled to be surveyor reviewed the (Medication Administrative the nurses documentation in on numerous dates, the mentation in the detail that the insulin was being en 1-3 hours after it was en to the resident.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>
	COVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	03/03/2013
(X4) ID PREFIX TAG			ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	checked three times a bedtime. Again, on not the facility staff had do section of the MAR the obtained 1-3 hours aff.  The surveyor noted the in the detail section, which is section is section. The surveyor did not a section is section. The surveyor did not accept final was wrong with the countries of the document would not accept final was wrong with the countries of the document which is section in the surveyor question computer problem was the surveyor asked the was for when the staff for insulin or Accu checked.	dered blood sugars to be a day before meals and at amerous dates and times ocumented in the detail at these blood sugars were ter meals and at bedtime.  The following documentation, which stated the following:  The following documentation, which stated the following:  The following documentation, which stated the following:  The following documentation that the following:  The surveyor notified the following documented or showed the corporate station that the computer signature and asked what computer and how long was	Fé	558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2013
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 658	No further information surveyor prior to the ed.  5. The facility staff count sheet as being and ending of the shift cart.  On 2/27/19 at 5:30 ar reviewing the narcotic medication carts local surveyor reviewed the February 2019. In do that the narcotic logs nurse signature when at the beginning or er The surveyor asked Linurse) #2 if these coulogbook was suppose have information miss stated, "The oncomin count the narcotics in each shift and day. A sign the log and that it was correct. You are without doing this."  On 3/5/19 at 4:20 pm administrative team of findings. The surveyor of nursing) how the cobe done by the nurse nurse coming in and the narcotics together name for the date and The nurses are not subefore this is completed.	failed to sign the narcotic accurate at the beginning it on 4 of 4 units medication in, the surveyor was a log on each of the ted on each unit. The ese books for January and ing so, the surveyor noted were left blank or had 1 in the narcotics were counted adding of the nursing shifts. PN (licensed practical and sheets in the narcotic ed to be left blank and/or sing on them. LPN #2 g and off going nurses' the medication cart for after you count, you are to means the narcotic count not supposed to leave  The bon stated, "The the nurse leaving will count to the that this was done. uppose to leave the building the fitme that this was done. uppose to leave the building	F 65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495417	B. WING		03/05/2019	
	ROVIDER OR SUPPLIER	_ RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	, 33.33.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLETION	
F 658	"Controlled SubstanNursing staff must at the end of each s the nurse going of d together. They must discrepancies to the long the surveyor prior to the form the	ation of narcotics titled, ace". This policy read in part, "a count controlled medications hift. The nurse coming in and uty must make the count at document and report any a director of nursing"  On was provided to the exit conference on 3/5/19. A cailed to follow professional are for medication asident #3. Registered Nurse on administered when the aually removed from the pill cup of Resident #3 was reviewed with 4/5/17 and readmitted as that included but not limited as that included but not limited as that included but not limited as legs syndrome, diastolic fibrillation, obstructive sleep and, constipation, idiopathic arthy, gastro-esophageal reflux mia, hypothyroidism, major, insomnia, anxiety, chronic min D deficiency, benign morbid obesity, hypertension, pulmonary disease, type 2	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>
	IDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	<u> </u>	33/33/2010
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The at now add state good was to the state g	11:17a.m. During rise #1 came in Relation and as given the pill curie surveyor review 19 physician's ord Lasix 40 mg (mill buth twice a day.  The surveyor review edication administ 20 a.m. box for Lath the initials of Redication administ edication was admitted the surveyor.  The surveyor informs above concern of DN stated if medicate to refusal, she was a curie to refusal, she was a curie surveyor interview and the surveyo	ewed Resident #3 on 2/27/19 If the interview, registered esident #3's room to ing medications. Resident #3 nt the diuretic as she was go to activities. Resident #3 p and removed the diuretic.  If the divertic as she was go to activities. Resident #3 p and removed the diuretic.  If the divertic as she was go to activities. Resident #3 had orders ders. Resident #3 had orders digram) tablet take one by  If the February 2019 If t	F 6	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495417	B. WING		C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2010	
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F 658	3/1/19 at 4:03 p.m.  The surveyor review standard of practice on 3/1/19. The polic Medication Administr Documentation must Reason(s) why a me administered, or refut The surveyor informed director of nursing, the nursing, and the corpabove concern on 3/0 on 3/5/19 at 4:26 p.m.  No further information exit conference on 3.7. For Resident #72 document a treatment of the surveyor information and the corpabove concern on 3/10 on 3/5/19 at 4:26 p.m.	ed the facility policy and for medication administration y titled "Documentation of ration" read in part, "3. include, as a minimum: e. dication was withheld, not sed."  ed the administrator, the ne assistant director of porate registered nurse of the 1/19 at 5:34 p.m. and again n.  In was provided prior to the (/5/19. the facility staff failed to not was not applied.	F 658			
	included but not limit chronic obstructive pobesity, difficulty wal Section C (cognitive annual MDS (minimu an ARD (assessmen included a BIMS (brisummary score of 18 Resident #72's compreviewed and contain "Potential for skin bro	ey on 02/16/17. Diagnoses ed to diabetes mellitus, ulmonary disease, morbid king, and muscle weakness.  patterns) of the Resident's and data set) assessment with the reference date) of 01/14/19 ef interview for mental status) of out of a possible 15 points.  prehensive care plan was need a problem area for eakdown related to impaired enceI am morbidly obese ture associated skin				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			03/0	; 05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	'	STREET ADDRESS, CITY, STATE, ZIP ( 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	CODE		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	( (EACH CORRECTIVE AC' CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 658	limited to, "Medication as ordered".  On 02/26/19 at 5:04p Resident #72. Reside surveyor that her gen being applied per ord the surveyor asked the cream had been apple #72 stated "I do not rowit. I can't apply it because on 02/28/19 at 9:45a was reviewed. Reside contained an order dapart "Apply Algera Crother day". The Reside treatment administrate February was reviewed scheduled to be admed:00am. The ETAR condate 02/27/19 at 6:00 #72's treatment was a 10:00am Resident #7 her genital warts treat yesterday as documen "The nurse said she will be the DON (director of the DON (director of the DON (director of the DON (director of the DON) was expects staff to do not given or refused.	entions included but were not as as ordered. Treatments  In the surveyor interviewed ent #72 voiced to the ital wart treatment was not er. On 02/27/19 at 10:33am are Resident if her Algera ited that morning. Resident emember the last time I had ause I can't see down there."  In Resident #72's record ent #72's physician's order ated 11/27/18 which read in eam to genital warts every dent's e-TAR (electronic ion record) for the month of ed. Algera cream was inistered on 02/27/19 at ontained initials under the am indicating that Resident applied. On 02/28/19 at 12 voiced to the surveyor that the the thick applied ented. Resident #72 stated would apply it today".  In the surveyor spoke to the surveyor spoke to the surveyor that the thick applied ented and applied ented applied ented applied to the surveyor that the surveyor spoke to the surveyor that the surveyor spoke to the surveyor that the surveyor that the surveyor that occument if the medication is	F6	558			
		ed a standards of practice istration and documentation.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C / <b>05/2019</b>
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 03	103/2013
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F 658	The facility was unable with the documentation	e to provide the surveyor on.	F 6	58		
		's Nursing Procedures, 6th Verify that the medication is t the proper time"				
	is anything written or record or proof for au Documentation within aspect of nursing practice documentation must be and flexible enough to maintain continuity of	page 477. "Documentation printed that is relied on as thorized persons. a client record is a vital citice. Nursing pe accurate, comprehensive				
	on 03/01/19 at 5:15pr Resident #72's treatm	vith the administrative team in regarding the concern of ient not being administered eatemnt documented as				
F 684 SS=E	provided to the survey Conference on 03/05/ Quality of Care	regarding this issue was y team prior to the exit '19.	F 6	84		4/19/19
	applies to all treatmer facility residents. Base assessment of a residental residents receive accordance with professions.	ndamental principle that nt and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495417	B. WING		C 03/05/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				514 NORTH MAIN STREET	
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 684	Continued From page		F 684	4	
	care plan, and the real This REQUIREMENT by:	sidents' choices. Γ is not met as evidenced			
		on, staff interview, clinical		Resident #89 no longer resides at the	e
		cility document review,		facility. For Resident #20, the physicia	
	facility staff failed to	•		and the responsible party were notifie	
	1 -	g for 11 of 28 residents in the		the Director of Nursing/Designee of the	
		dent #89, 20, 110, 36, 34,		variance in obtaining accuchecks for	
	91, 72, 47, 15, 17, ar	nd 51).		following dates and times: 2/5/19 at 7	
	The finalines in alredo	1.		am, 2/6/19 at 1:57 am, 2/6/19 at 8:26	
	The findings included	1:		as well as the insulin variances in the	
	1. The facility staff	failed to follow physician		February 2019 Medication Administra Record for Lantus including Lantus	ILIOIT
		nt #89 returned from being		administered on 2/9/19 at 3:11 am. T	here
	seen at the emergen			were no adverse effects for Resident	
	_	mitted to the facility on		Resident #110 no longer resides at the	
		wing diagnoses of, but not		facility. For Resident #36, the physicia	
		pressure and respiratory		and the responsible party have been	
	failure. On the admis	ssion MDS (Minimum Data		notified by the Director of	
	1	ssessment Reference Date)		Nursing/Designee regarding	
		it was coded as requiring		administration of insulin/Lantus 1-3 ho	
		of 2 staff members for		after it was scheduled to be administe	ered
		al hygiene. Resident #89		in January 2019. The physician and	
		eing totally dependent on 2		responsible party were also notified	
	staff members for bat	tning.		regarding Lantus documented as	h4
	During the clinical rea	cord review on 2/29/10, the		administered on 2/25/19 at 10:34 am	~
	_	cord review on 2/28/19, the Resident #89 was in the		was scheduled for 1/21/19. The physi and the responsible party have been	Ciail
	_	2/6/19. The surveyor could		notified regarding accuchecks obtained	ed in
		ntation of this visit in the		January 2019 1-3 hours after meals a	
	-	surveyor requested and		bedtime as well as accucheck	-
		is visit. The DON (director of		documented as obtained on 2/25/19 a	at
	-	where these copies were		10:34 am but was originally schedule	
		ted, "I had to call the hospital		1/15/19 at 7:30 pm. There were no	
		over to me." According to		adverse effects for the resident relate	d to
		he emergency room doctor		these variances. The notifications have	
		e resident to be seen by the		been documented in the clinical recor	d by
	doctor in the facility in	n 2-3 days for a follow up.		the Director of Nursing/Designee.	
				Resident #91 no longer resides in the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	NG _		,	C
		495417	B. WING			1	05/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPPING	TON PLACE AT RURAL	DETDEAT		51	14 NORTH MAIN STREET		
CARRING	TON PLACE AT KUKAL	RETREAT		R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page The surveyor reviewer Resident #89. There the clinical record with doctor did not see the The surveyor notified the above documented pm in the conference The surveyor interviewed the clinical only seen on 2/18/19  No further information surveyor prior to the 2. The facility staff for orders for obtaining A and the administration Resident #20. Resident #20 was ad 8/31/18 with the follow limited to heart failure pressure, dementia, depression and respinguarterly MDS (Mining (Assessment reference resident was coded a Interview for Mental Spossible score of 15. coded as requiring examembers for dressing with the condensation of the coded as requiring examembers for dressing examembers for dressing the coded as requiring examembers for dressing the code as requiring examembers for dressing the coded as requiring examembers for dressing the code as requiring examemb	ed the progress notes for were no progress notes in hin this period. The facility e resident until 2/18/19.  The administrative team of ed findings on 3/1/19 at 5:33 room.  Wed the facility doctor on ely 2 pm. The doctor record and stated, "He was for another problem."  In was provided to the exit conference on 3/5/19.  Silled to follow physician accu checks (blood sugar) no finsulin (blood sugar) for mitted to the facility on wing diagnoses of, but not e, diabetes, high blood		684	facility. For Resident #34 the physician and the responsible party have been notified by the Director of Nursing/Designee regarding the medication variance for Metformin ordered on 2/28/2019 and started on 3/1/19. There were no adverse effects the resident related to the medication variance. Fore Resident #72, the physician and responsible party have been notified by the Director of Nursing/Designee regarding the medication variance on 2/27/2019 at 6: am for Algera cream. The licensed nurshas been in-serviced regarding the six rights of medication administration to include accurate documentation of medications after administration not before. There were no adverse effects the resident related to the medication variance. For Resident #15, the physici has been notified by the Director of Nursing/Designee regarding the variance related to vital signs and weights order on 2/23/19 for one (1) week. There was no adverse effect for Resident #15 related to the variance involving vital signs and weights everyday for one (1) week. For Resident #17, the physician and responsible party were notified by the Director of Nursing/Designee of the following medication variances: 2/27/19	for  00 se (6) for ed s ted I	
	through 3/5/19, the s (Medication Administ report for February 2 not being performed	cord review from 2/26/18 urveyor noted on the MAR ration Record) and the detail 019, that Accu checks were as ordered by the doctor. d the Accu checks to be			9:00 pm for Zatador and Seroquel, 2/28/19 at 9:00 a, for Zatador, Mobic at Propylene glycol eye drops. The physic has also been notified by the Director of Nursing/Designee of the accucheck variances regarding notification parameters in February 2019. These	cian	

		E SURVEY MPLETED				
			A. BUILDIN	G		
		495417	B. WING _		0:	C 3/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	5/00/2010
				514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368		
(VA) ID	STIWWADA S.	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	PECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	e 73	F 6	84		
F 684	obtained three times at bedtime. According to the deta Accu checks were not completed as ordere following notations:  " "7:57 am 2/5/2/4/19)  "1:51 am 2/6/19/2/5/19  "8:26 am 2/6/19/2/5/19  The surveyor also not given to the resident noted the following in resident's MAR which (Scheduled: 9:00 pm The surveyor continuthroughout the MAR  On 3/1/19 at approxical asked the corporate and times meant on corporate MDS nursidate is when the Accuracy administrated. The rare the schedule data be done."  On 3/5/19 at 4:20 pm administrative team of findings. The survey documentation to the reviewed it. The corexplanation in regard	every day before meals and all report of the MAR, the of documented as being d. The surveyor noted the 19 (Scheduled: 5:30 pm 9 (Scheduled: 9:00 pm 9 (Scheduled: 5:30 pm 9 (Sch	F 6	include: 2/23/19 at 7:30 am blowas greater than 450; at 11:30 2/1/19, 2/7/19, 2/10/19, 2/19/19 2/23/19 blood glucose was great 450; and at 5:30 pm on 2/1/19, 2/8/19 blood glucose was great 450. The notifications have bee documented in the clinical record Director of Nursing/Designee. The notified by the Director of Nursing/Designee and responsible party notified by the Director of Nursing/Designee regarding the medication variances: Cipro frothrough 1/24/19 for a total of 29 instead of the ordered 28 dosest gentamycin from 1/29/19 through in which the electronic medication administration record reflects twenty-seven (27) doses admininstead of the prescribed forty-the doses. There were no adverse the resident related to the antibivariances. For Resident #51, the physician and the responsible pheen notified by the Director of Nursing/Designee of the medical variances involving Klonopin or following dates 2/3/19, 2/4/19, 2/2/12/2019, 2/16/19, 2/21/19, 2/2/23/19 and 2/24/19. The medical nurse observed on 2/27/19 at 6 no longer employed at the facili physician and the responsible pheen notified of the medication on 2/27/19 at 6:30 am involving	am on and ater than 2/2/19 and er than and ater than and ater than and by the There were ent related at #47, the avere ent following m 1/11/19 of doses and ateret wo (42) effects for iotic e and ateret have entire entry have entry have ation at the 2/5/19, 22/19, cation and ateret and and ateret entry have entry have variance	
		exit conference on 3/5/19.		Notifications have been documenthe Director of Nursing/Designe	ented by	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495417	B. WING				05/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	00/2010
				5	14 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		R	URAL RETREAT, VA 24368		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 74	F	684			
	· -	iled to follow physician			clinical record. There were no adverse		
	_	stration of an antibiotic to			effects for the resident related to the		
	Resident #110.				medication variances.		
	Resident #110 was a	dmitted to the facility on			Reviews have been conducted by the		
	1/7/19 with the follow	ing diagnoses of, but not			Administrator/Director of		
	limited to anemia, hig				Nursing/Designee in the following area		
		UTI and multidrug resistant			to identify further variances and verify t		
		mission MDS (Minimum			medication administration is consistent		
	Data Set) with an ARD (Assessment Reference Date) of 1/14/19, the resident was coded as				with physician □s orders:		
	having a BIMS (Brief Interview for Mental Status)				(A) The Administrator/Director of Nursing/Designee has reviewed the		
		ssible score of 15. Resident			emergency room documentation for		
		as requiring extensive			resident □s ER visits within the previou	s	
		members for dressing and			thirty (30) days to ensure that		
	personal hygiene.	3			recommendations have been followed		
					and residents returning to the facility from	om	
	During the clinical red	cord review from 2/26/19			the ER have been seen by the physicia		
		urveyor noted that the			upon returning and hospital paperwork		
		to have Vancomycin 500			related to the ER visit are present on the	ie	
		days. This order was			clinical records.		
	_	strated by the facility staff on			(B) The Director of Nursing/Designee	nas	
		On the detail section of the ication Administration			reviewed Electronic Medication Administration Records and physician	10	
		2019, the following was			orders for the previous thirty (30) days		
	documented:	2013, the following was			residents with physician □s orders for	101	
		3/19 (Scheduled for 2/23/19			accuchecks/blood glucose checks,		
		available from pharmacy.			specific notification parameters, and		
	Pharmacy notified	. ,			insulin administration to identify further		
	" 3:17 am 3/9/19 (	Scheduled for 3/2/19 at 9:00			variances requiring correction and		
	pm not given; awaitin	g pharmacy arrival"			notification to the physician and		
					responsible party and verify that		
	•	the administrative team on			physician s orders have been followed		
	3/5/19 at 4:20 pm in t	ne conterence room.			(C) The Director of Nursing/Designee	nas	
	No further information	a waa providad ta the			reviewed the Electronic Medication	<b>□</b>	
	No further information	n was provided to the exit conference on 3/5/19.			Administration Records and physician	<b>J</b> S	
	surveyor prior to the t	EAR COMETERICE ON 3/5/19.			orders for the previous (30) days for residents with physician orders for		
	4 The facility staff fa	iled to follow physician			antibiotic medications as well as diabet	ric	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	NG _	<del></del>	,	С
		495417	B. WING				05/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT RURAL	RETREAT			14 NORTH MAIN STREET		
<b>67 II II II II</b>	TOTAL PROPERTY.			R	RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	2.75		004			
F 00 <del>4</del>	Continued From page		-	684	li di la salata di		
	_	Accu (blood sugar) checks			medications i.e. Metformin to identify		
		ation of insulin for Resident			further variances requiring correction a	na	
	#36.	mitted to the facility on			notification to the physician and responsible party and to verify that		
		ing diagnoses of, but not			medications have been administered p	er	
	limited to anemia, he				the physician sorders.	Ci	
	pressure, diabetes ar				(D) The Director of Nursing/Designee	has	
		num Data Set) with an ARD			reviewed physician □s orders, EMARs,		
		nce Date) of 12/18/18, the			and notes for the previous thirty (30) d		
	resident was coded a			to identify residents with physician is			
	Interview of Mental S			orders to have vital signs and or weigh	ts		
	possible score of 15.	Resident #36 was also			obtained at an increased frequency an	d	
		ktensive assistance of 2 staff			determine if these were obtained and		
		g, personal hygiene and			documented as ordered.		
	bathing.				(E) The Director of Nursing/Designee		
					compared the phsicians s orders with		
		hysician order for "Lantus			EMAR for the previous thirty (30) days	το	
	, , ,	Administer every night at			verify that medications have been	nd	
		dication was scheduled to be urveyor reviewed the			administered per physician □s orders a identify any further variances/omission		
		Medication Administrative			requiring correction and further notifica		
		ne nurses documentation in			to the physician and responsible party.		
	, •	n numerous dates, the			(F) The Director of Nursing/Designee		
	_	mentation in the detail			compare the current physician □s orde		
	-	nat the insulin was being			with the medications available in the		
	administrated as give	en 1-3 hours after it was			medication cart to ensure that physicia	ns	
	scheduled to be give	n to the resident.			ordered medications are available for		
		dered blood sugars to be			administration.		
		a day before meals and at					
		umerous dates and times			Education has been provided by the		
	•	ocumented in the detail			Director of Nursing/Designee to the		
		nat these blood sugars were			Licensed Nurses and interdisciplinary	40	
	optained 1-3 hours at	fter meals and at bedtime.			team on 04/17/19, 04/18/19 and 04/19	19	
	The curveyer peter 4	ho following door-montation			regarding the following topics:	_	
	•	he following documentation,			(A) Hospital discharge paperwork form		
		which stated the following:accu checksscheduled			ER visits should be filed on the clinical record upon return. Physicians orders		
	for 1/15/19 at 7:30 ar				communicated in the hospital ER		
		administrated, computer did			discharge paperwork must be followed	in	
	i initialo of Huroci do c	animinotratou, computer ala	1		i alegnange paper work index be followed		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	I' '		TE SURVEY MPLETED
						С
		495417	B. WING _		0	3/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
CARRING	TON DI ACE AT DUD	L DETREAT		514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURA	AL RETREAT		RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	age 76	F 6	84		
1 004	not accept final sig 10:34 am 2/25/19 1/21/19 9:00 pm. I administrated, comsignature"  The surveyor did not the physician had I of the above docured the above docured administrative team findings. The surveyourse of the docume would not accept final was wrong with the this being noted for the document of the docu	natureLantus scheduled for Locked by (initials of nurse) as inputer did not accept final  of find any documentation that been made of aware or notified mented findings.  om, the surveyor notified the m of the above documented eyor showed the corporate mentation that the computer mal signature and asked what e computer and how long was m. The corporate nurse	F	a timely fashion. Residents to the ER for evaluation should the physicians list at the facili return to the facility for follow assessment and physicians (B) Physician sorders must regarding these areas: medicated be administered via the six (6 medication administration and permitted time frame for medication administration. Medication administration and the medication administered from the medication administered EMAR. Any variance or physician timelity the responsible party to relay	be placed on ity upon up visit. It be followed cations must be nights of d within the lication dministration dministration ed on the visit of the lication order ires that the ly as well as the details of	
	the surveyor's quethis computer probfacility. The survey process was for why physician order for DON stated, "The medications as ord No further informat surveyor prior to the 5. The facility stafforders for obtaining administration of Resident #91 was 1/31/19 with the folimited to anemia, arenal disease, diab blood pressure. O (Minimum Data Se	mentation and did not answer stions as to why or how long lem was going on in the yor asked the DON what the nen the staff receives a insulin or Accu checks. The nurses are to give the lered by the physician."  ion was provided to the e exit conference on 3/5/19.  If failed to follow physician g Accu checks and/or the esident #91's insulin. admitted to the facility on lowing diagnoses of, but not atrial fibrillation, end stage letes, heart failure and high in the admission MDS to with an ARD (Assessment late of 2/7/19, the resident was		the variance. Notifications to and responsible party must be documented in the clinical re includes medications that are. The physician may wish to git to hold the medication this in routes of medications, insulir accuchecks, specifically order notification parameters, vital physician sordered weights medications are identified as please contract the physician pharmacy, the responsible parameter of Nursing/Designee need to be taken at that time medication or other physician (C) The Administrator/Direct Nursing/Designee will complete following reviews for three (3) weekly for three (3) months: discharge documents will be ensure that physician orders	cord. This e unavailable. e unavailable. e unavailable. e unavailable. e red signs, s. If unavailable n, the arty and the e. Steps will to obtain the ns orders. eor of ete the ) residents Hospital, ER reviewed to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		، ا	C
		495417	B. WING				05/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
				5′	14 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		R	URAL RETREAT, VA 24368		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 77	F	684			
	coded as requiring ex	ktensive assistance of 2 staff			communicated in the discharge		
		g, and personal hygiene.			paperwork have been followed and tha	t	
	1	so coded as being totally			the ER paperwork is available on the		
		members for bathing.			clinical record. The weekly review will a	also	
	The surveyor reviewe	ed the clinical record of			include review of the facility ☐s physicia	ins	
	Resident #91 on 2/26	6/19 through 3/5/19. During			list to ensure that the residents transfer	red	
		yor noted the following			back to the facility from the ER have be	en	
	physician's orders:				added to the list of residents to be seen	1	
					and assessed by the practitioner.		
		three times every day and at			(D) The Director of Nursing/Designee	WIII	
	1	:30 am, 4:30 pm and 9:00			review active physician s orders and		
	pm) o Lantus Give 40 ເ	units in morning"			current EMAR for residents with physician sorders for accuchecks		
	Lantus Give 40 t	ariits iir morning			specific notification parameters, and		
	The surveyor reviewe	ed the MAR (Medication			insulin administration to ensure that the	ese	
	_	d) for Resident #91 for			things were carried out following the	,,,,	
	I .	dent #91 goes out of the			physicians order and documented		
	_	Monday, Wednesday and			appropriately in the clinical record.		
	Friday. During this re	view, the surveyor noted on			(E) The Director of Nursing/Designee	will	
	dialysis days the facil	lity staff documented in the			review physician□s orders and compar	·e	
		MAR for the Accu checks and			to electronic medication administration		
	I .	given at 6:30 am that the			record for three (3) residents with order	s	
		ilable. In addition, the			for antibiotic medications as well as		
		as scheduled for 6:30 am on			diabetic medication i.e. Metformin to		
	l	ot being administered to the			ensure that medications are available a	-	
	resident either becau				administered as ordered by the physici and documented appropriately in the	an	
	unavailable or gone t	o dialysis.			clinical record.		
	In the detail section o	of the resident's MAR for			(F) The Director of Nursing/Designee	will	
	February, the survey				review active physician □s orders and	••••	
	documentation:	3			compare these to the electronic		
					medication administration record for the	ree	
	o "11:24 am 2/2	25/19 (Scheduled 2/5/19 9			(3) residents weekly for three (3) month	าร.	
	pm) Accu checks three	ee times every day before			To ensure that meds are administered		
	meals and at bedtime	e			ordered by the physician within the		
	I .	) (Scheduled 2/10/19 6:30			acceptable time frame and administrati		
		ee times every day before			of medication is documented accuratel	y in	
	meals and at bedtime				the clinical record. Additionally, if	ĺ	
	o 11:25 am 2/25/19	9 (Scheduled 4:30 pm			variances are identified the review will		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	(X3	) DATE SURVEY COMPLETED
		495417	B. WING _			C <b>03/05/2019</b>
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	2/10/19) Accu check before meals and at o 11:26 am 2/25/2/13/19) Accu check before meals and at o 11:26 am 2/25/NovalogInject 5 u On 3/1/19 at approxasked corporate MD and times meant. The first date of the Accu checks and being obtained and/and times in the parthe Accu checks or in obtained and/or give On 3/5/19 at 4:20 pradministrative team findings. The survey nurse the document The corporate nurse answer any question surveyor asked the what was the standawhen administering blood sugars. The Inhour before and after schedule for." The street of the facility's policy or the surveyor receiv "Documentation of the which read in part" medication must be after (never before)	st three times every day bedtime  19 (Scheduled 6:30 am ks three times every day bedtime  19 (Scheduled 6 pm 2/18/19) nits"  19 (Scheduled 6 pm 2/18/19) nits"  imately 1 pm, the surveyor of so nurse what these dates he corporate MDS nurse es and times are the times do insulin were documented as or administrated. The dates enthesis is the date and time insulin were scheduled to be en."  Important the surveyor notified the of the above documented yor showed the corporate ation of the above findings. The DON (director of nursing) and for the nurses' to follow medications or obtaining DON stated, "they have an er the time that these were surveyor requested a copy of n documentation.  The determinant the facility's policy titled dedication Administration"Administration of documented immediately	F 6	need to ensure that the physical responsible party are notification documented.  The results of the interviews will be discussed by the Dire Nursing/Designee monthly from the at the Quality Assura Performance Improvement (Meeting (QAPI). The interdisteam (IDT) will make recomfor revisions as indicated ne sustain substantial compliant	d, and s and reviews ector of or three (3) ance Committee sciplinary mendations ccessary to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	· ·	0.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	6. The facility staff far physician ordered meresident #34.  Resident #34 was rea 9/12/15 with the follow limited to anemia, ne tract infection, demer depression. On the condition of 12/17/18, the having a BIMS (Brieff score of 7 out of a post was also coded assistance of 2 staff personal hygiene and 2 staff members for both the surveyor note clinical record dated pm which stated, "Meresident post post post post post post post pos	exit conference on 3/5/19.  Alled to administer a dedication, Metformin, for admitted to the facility on wing diagnoses of, but not urogenic bladder, urinary ntia, Multiple Sclerosis and quarterly MDS (Minimum D (Assessment Reference eresident was coded as Interview for Mental Status) assible score of 15. Resident as requiring extensive members for dressing, debeing totally dependent on bathing.  Cord review 3/1/19 at 9:45 ded a physician order in the and timed for 2/28/19 at 3:30 deformin 250 mg (milligram) wice a day)."  Eyor notified the unit pove documented findings S (Minimum Data Set) desent. The resident was not as ordered on 2/28/19 until	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	` '	(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C 3/05/2019
	ROVIDER OR SUPPLIER	_ RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		3/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 80	F 68	84		
		the facility staff failed to nent Algera as ordered by the				
	admitted to the facilii included but not limi chronic obstructive pobesity, difficulty was Section C (cognitive annual MDS (minim an ARD (assessmer included a BIMS (br summary score of 1 Resident #72's com reviewed and contai "Potential for skin br mobility and incontir and often have mois	eview Resident #72 was ty on 02/16/17. Diagnoses ted to diabetes mellitus, bulmonary disease, morbid liking, and muscle weakness.  patterns) of the Resident's um data set) assessment with nt reference date) of 01/14/19 ief interview for mental status) 5 out of a possible 15 points.  prehensive care plan was ined a problem area for reakdown related to impaired henceI am morbidly obese sture associated skin rentions included but were not				
	limited to, "Medication as ordered".  On 02/26/19 at 5:04 Resident #72. Resident #72. Resident applied per or the surveyor asked cream had been applied per or the surveyor asked in the surveyor aske	pm the surveyor interviewed lent #72 voiced to the inital wart treatment was not der. On 02/27/19 at 10:33am the Resident if her Algera blied that morning. Resident remember the last time I had cause I can't see down there."  Oam Resident #72's record dent #72's physician's order dated 11/27/18 which read in cream to genital warts every ident's e-TAR (electronic				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER	AL RETREAT		5.11916	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE COMPLETION
F 684	February was revies scheduled to be ad 6:00am. The ETAR date 02/27/19 at 6: #72's treatment was 10:05am Resident her genital warts tryesterday as docur "The nurse said shound the surveyor that hand stated "I have physician's orders"  The surveyor spok on 03/01/19 at 5:18 Resident #72's treatment as ordered.  No further informat provided to the surconference on 03/08. For Resident #15 was 11/22/15 and readr included heart failur disease, psychotic tract infection (UTI) disturbance, dysphweakness, and diff quarterly minimum assessment reference on 3/15 on the	ration record) for the month of ewed. Algera cream was iministered on 02/27/19 at a contained initials under the 00am indicating that Resident is applied. On 02/28/19 at #72 voiced to the surveyor that eatment was not applied mented. Resident #72 stated in ewould apply it today.  Opm Resident #72 voiced to the er cream was applied today in ever seen nurses not follow in ewith the administrative team of sym regarding the concern of eatment not being administered in the exit 155/19.	F 68	4	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	E	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	je 82	F 6	84		
	The assessment ind ambulated and used assistance, was free incontinent, and on a Clinical record reviet dated 2/23/19 for da and weight daily time. There was a nursing indicating there was daily for a week". O and pulse was docu documented after 2/nursing was notified was unable to locate	the toilet with 1-2 person juently, but not always, a prompted toileting program.  w revealed a physician order ily blood pressure, heart rate, es one week and record.				
	physician orders for were followed and the when those orders we ensure that the physinformation necessal. Resident #17 was at 4/19/16. Diagnoses gastroesophageal remellitus, anxiety, depending pain. On the assessment reference scored 15/15 on the status and was assessment.	facility staff failed to ensure medication administration nat the physician was notified were not followed, and to sician was notified of ry for diabetes management.  Idmitted to the facility on included hypertension, efflux disease, diabetes pression, asthma, and evanual assessment with the december of the provided hypertension and evanual assessment with the december of the provided hypertension as the provided hypertension as the provided hypertension, efflux disease, diabetes pression, asthma, and evanual assessment with the december of the provided hypertension as the provided hyperte				
	Medication orders in	cluded Mobic 7.5 milligram				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	` '	TE SURVEY MPLETED
		495417	B. WING _			C <b>3/05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		3/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	eye drops one drop e	daily started 1/10/19, Zatador each eye twice a day,	F 6	84		
		ns one tablet by mouth at ne glycol 1 drop each eye 4				
	surveyor noted that of and Seroquel were do administered- meds r AM Zatador, Mobic, a	review on 2/28/19, the on 2/27/18 at 9 PM Zatador ocumented as "not not available". On 2/28/18 9 and propylene glycol eye ted as "not administered-				
	and at bedtime (notify <60 or >450). The dogreater than 450 at 7	ues every day before meals y MD for BG(blood glucose) ocumented blood sugar was :30 on February 23, at 11:30 19, and 23, at 5:30 on				
	physician or nurse pr medication omissions glucose readings. No	ng notes to indicate that the actitioner were notified of the sor of the high blood ursing staff were unable to sician was routinely notified				
	notified of the concer notified when medica or when the blood glu	d director of nursing were n that the physician was not tions were not administered ucose levels were over 450 lld be adjusted if necessary eeting on 3/1/19.				
		7, facility staff failed to for the ordered duration.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	' '	TE SURVEY MPLETED
		495417	B. WING			C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		3.33.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	4/6/16. Diagnoses in hypertension, periph infection, diabetes of Parkinson's, schizop disease, dysphagia, and methicillin resist On the quarterly min with assessment referesident scored 11/1 mental status and word delirium, psychosis During clinical record a telephone order da (milligram) PO (by milligram) PO (by mil	dmitted to the facility on included heart failure, eral vascular disease, wound itellitus, dementia, hemiplegia, hrenia, cardiopulmonary open wound to the left foot ant staphylococcus infection. Imum data set assessment erence date 2/12/19, the 5 on the brief interview for as assessed as without signs s, or behavior symptoms.  If review, the surveyor noted ated 1/11/19 for cipro 500 mg routh) BID (twice a day) X 14 res). The medication documented administration 24 for a total of 29 doses. A gentamycin 60 mg IM right in on 1/29/19. The order was res a day from 1/29 through The MAR indicated the remedication once on 80/19, 1/31 through 2/6, once so on 2/8. The MAR indicated day and director of nursing were fon of antibiotic medications retings on 3/4/19.  1, facility staff failed to	F 68	34		

			3) DATE SURVEY COMPLETED				
		495417	B. WING _			C 03/05/2	2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI E APPROPRIA	-	(X5) DMPLETION DATE
F 684		zures, derebral palsy,	F 6	84			
	set assessment with 3/29/18, the resident interview for mental s	order, anxiety, and e quarterly minimum data assessment reference date scored 9/15 on the brief tatus and was assessed as um, psychosis, or behaviors					
	klonopin 1 milligram to equal 1.5 milligram by bedtime. The MAR (precord indicated the radministered at least administrations on Fe 21, 22, 23 and 24. Somedication nurse hold 2/27/19 afterdropping. The nurse told the superior administer it because on time administration clinical record and shadingiven late. The nurse notes at 8:59 AM "me physician aware". The what she told the phyphysician had ordere administerd. The nurse administerd aphysician the surveyor medications were mis reflected the physcian physician had not becalled the physcian of	se said she intended to communication form to nat the medication had been or asked how often seed and the record nas aware when the en notified. The nurse then ffice and reported that the					
	called the physcian o nurse had been unab 6:30 AM because the	ffice and reported that the le to give the klonopin at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY					
						(	С
		495417	B. WING _			03/	05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	the physician response would rather have an would have until 10 A The physician common or time and said only administered. Please with questions. No nexplain the medicaitod several hours late that Facility administration concern as the incided Treatment/Svcs to Pr CFR(s): 483.25(b)(1) Pressure Based on the compressident, the facility in (i) A resident receives professional standard pressure ulcers and culcers unless the indidemonstrates that the (ii) A resident with prenecessary treatment with professional standard with professi	surveyor was unable to hear se, but the nurse said she order to give it at 9 so she all to give the medication. Unication form listed no date "6:30 AM medication not refer to [director of nursing] tursing note was made to n being administered at day.  In was made aware of the ent occurred on 2/27/19. Event/Heal Pressure Ulcer (i)(ii)  grity tre ulcers. Enensive assessment of a nust ensure that-se care, consistent with the sof practice, to prevent does not develop pressure vidual's clinical condition en ey were unavoidable; and essure ulcers receives and services, consistent		684	DEFICIENCY)		4/19/19
	new ulcers from dever This REQUIREMENT by: Based on staff intervand facility document provide wound treatment the survey sample (R	eloping.  is not met as evidenced  iew, clinical record review, review, facility staff failed to nent for 1 of 28 residents in			For Resident #47, the physician and the responsible party were notified that the treatment was held on 2/11/19. There were no adverse effect for the resident related to the treatment variance.	vas	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′			(X3) DATE COMP	SURVEY LETED
		495417	B. WING				05/2019
NAME OF DE	ROVIDER OR SUPPLIER	100.11	<del></del>	12	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019
NAME OF T	COVIDEIX OIX 301 1 EIEIX						
CARRING'	TON PLACE AT RURAL I	RETREAT			14 NORTH MAIN STREET		
				R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	· 87	F 6	86			
	4/6/16. Diagnoses in	cluded heart failure,			The Director of Nursing/Designee has		
	•	ral vascular disease, wound			conducted a review of physician □s ord	ers	
	* * * * * * * * * * * * * * * * * * * *	ellitus, dementia, hemiplegia,			and treatment administration records for		
		renia, cardiopulmonary			the previous thirty (30) days to identify		
	disease, dysphagia, d	pen wound to the left foot			further variances requiring corrective		
	and methicillin resista	nt staphylococcus infection.			measures and physician and responsib	le	
	On the quarterly minir	num data set assessment			party notifications, to ensure treatments	3	
		rence date 2/12/19, the			are completed per the physician □s ord	er.	
		on the brief interview for					
		s assessed as without signs			Education has been provided by the		
	of delirium, psychosis	, or behavior symptoms.			Director of Nursing/Designee to Licens		
	During clinical reserve	maniano de anomonos matad			Nurses regarding completing treatment	.S	
		review, the surveyor noted ed 1/14/19 for clean ulcer			as ordered by the physician and documenting the treatment administration	ion	
		rinse, pat dry, apply calcium			appropriately after it is completed. A	OII	
		d, skin prep to wound, and			review will be completed by the Director	ır of	
		and kerlix every day and			Nursing/Designee of physician orders f		
	PRN. The treatment				treatments and the ETAR for three (3)		
	indicated on 2/11/19 "	was held. special			residents per week for three (3) months	s to	
		The resident's nurse and			ensure treatments are being administer		
	the director of nursing	were unable to explain			as ordered by the physician and		
	what the special requ	irement was or why the			documented appropriately after		
		en done. There was no			administration.		
	nursing progress note	for that date.					
					The results of the interviews and review	vs	
		documented on 1/11/19, a			will be discussed by the Director of		
		not dressing applied with			Nursing/Designee monthly for three (3)		
		explain why the dressing			months at the Quality Assurance		
	was not applied.				Performance Improvement Committee		
	The administrator and	director of nursing were			Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations	_	
		ons in wound care during			for revisions as indicated necessary to	'	
	summary meetings or				sustain substantial compliance.		
F 687	Foot Care		F 6	87			4/19/19
SS=D	CFR(s): 483.25(b)(2)(	i)(ii)	. 0	"			10/10
33-0	(-) (-)(-)(-)(-)						
	§483.25(b)(2) Foot ca	ire.					
		nts receive proper treatment					
			<u> </u>				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	03/05/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 687	health, the facility mu (i) Provide foot care with professional sta to prevent complicati medical condition(s) (ii) If necessary, assi appointments with a arranging for transpo appointments. This REQUIREMEN' by: Based on staff inten- review, the facility sta services consistent of practice to prevent or resident's medical co (Resident #11).  The findings included The facility staff faile to Resident #11 in a physician ordered a for ingrown toenails a 500 mg (milligrams) days. Resident #11 when the resident wa ingrown toenail and si The clinical record of 2/26/19 through 3/5/ admitted to the facility 7/14/18 with diagnos limited to acute respi chronic respiratory for metabolic encephalo	mobility and good foot ust: and treatment, in accordance ndards of practice, including ons from the resident's and st the resident in making qualified person, and ortation to and from such.  T is not met as evidenced view and clinical record aff failed to provide podiatry with professional standards of complications from the ordition for 1 of 28 residents.  d: d to provide podiatry services timely manner. The podiatry consult on 12/10/18 and was started on Keflex qid (four times a day) x 10 was not seen until 2/7/19 as treated again for an seen by the podiatrist.  f Resident #11 was reviewed 19. Resident #11 was reviewed 19. Resident #11 was reviewed that included but not ratory failure with hypoxia, ailure with hypercapnia, pathy, difficulty in walking,	F 68	For Resident #11, podiatry services provided.  A review has been completed by the Administrator/Director of Nursing/Designee for current resider ensure that podiatry services have be provided.  Education has been provided to the licensed nurses and the interdisciplinateam by the Administrator/Director of Nursing/Designee regarding provisio podiatry services. A review will be completed by the Administrator/Designeekly for three (3) residents for three months to ensure resident are having podiatry services coordinated, set up provided to them.  The results of the interviews and reviwill be discussed by the Director of Nursing/Designee monthly for three (months at the Quality Assurance Performance Improvement Committee	nts to een  nary f n of gnee ee (3) g and ee
	The facility staff faile to Resident #11 in a physician ordered a for ingrown toenails a 500 mg (milligrams) days. Resident #11 when the resident waingrown toenail and street to the facility 7/14/18 with diagnost limited to acute respichronic respiratory fametabolic encephalogical for the facility 7/14/18 with diagnost limited to acute respications of the facility fametabolic encephalogical facility family f	d to provide podiatry services timely manner. The podiatry consult on 12/10/18 and was started on Keflex qid (four times a day) x 10 was not seen until 2/7/19 as treated again for an seen by the podiatrist.  f Resident #11 was reviewed 19. Resident #11 was ry 2/4/15 and readmitted es that included but not ratory failure with hypoxia, ailure with hypercapnia, pathy, difficulty in walking, cute kidney failure, chronic		Education has been provided to the licensed nurses and the interdisciplin team by the Administrator/Director of Nursing/Designee regarding provisio podiatry services. A review will be completed by the Administrator/Designeekly for three (3) residents for three months to ensure resident are having podiatry services coordinated, set up provided to them.  The results of the interviews and reviwill be discussed by the Director of Nursing/Designee monthly for three months at the Quality Assurance	nary f n of gnee ee (3) g and diews (3)

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	, ,	ATE SURVEY DMPLETED	
		495417	B. WING _			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	. RETREAT	STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 687	depressive disorder, polyneuropathy, hyp reflux disease, adult schizoaffective disor anemia, dysphagia, disease, urinary tracobstructive pulmona deficiency.  Resident #11's quarassessment with an (ARD) of 2/13/19 as BIMS (brief interview There were no asse delirium, behaviors at the clinical record of communication form "Rsdt (resident) c/o and right) great toe pedge of toenail. Are	y, hypothyroidism, major bipolar disorder, okalemia, gastro-esophageal failure to thrive, der, urethral stricture, constipation, Parkinson's tinfection, chronic ry disease, and Vitamin terly minimum data set (MDS) assessment reference date sessed the resident with a v for mental status) as 15. ssed signs or symptoms of affecting others or psychosis.	F 6	for revisions as indicated sustain substantial comp	-		
	response dated 12/10 order dated 12/10/18 mg (milligrams) po ( day) x 10 days. 2. C  The surveyor was un consult in the clinical corporate registered at 5:42 p.m.  The surveyor receive 2/7/19-two months at 12/10/18. The podia seen for new foot an	ne physician with a return 0/18 "See order." Physician 3 read "1. Start Keflex 500 by mouth) qid (four times a consult podiatry."  I record and informed the nurse of the above on 3/4/19  ed the podiatry consult dated ofter the original order of atry consult read "Pt (patient) and nail evaluation and complaints. Left hallux nails					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495417	B. WING _		0	C <b>3/05/2019</b>
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	- ' -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 687	Continued From page		F 6	87		
	read most of handwrit prescribed Keflex 500 x 7 days. The surveyor asked the podiatry services computated some residents as well as seen in the surveyor informed director of nursing, the nursing, the regional cregistered nurse and nurse MDS of the about 4:26 p.m.  The surveyor reviewee "Nursing Care of the I Mellitus" on 3/5/19. Tomplications Associated 5. Foot compliskin, calluses, poor ci	d the administrator, the e assistant director of executive, the corporate the corporate registered ove concern on 3/5/19 at  d the facility policy on Resident with Diabetes the policy read under intended with Diabetes to ications-neuropathy, dry rculation, ulcers. Skin and				
	trimmed by personnel be regular associates podiatrist). 9. Care of should be referred to may require health caintervention)."	B. Toenails should only be qualified to do so (this can , and does not have to be a corns and/or calluses qualified individuals (which are provider or podiatrist ) was provided prior to the				
F 690 SS=E	exit conference on 3/8 Bowel/Bladder Incont CFR(s): 483.25(e)(1)-	inence, Catheter, UTI	F 6	90		4/19/19
	§483.25(e) Incontiner §483.25(e)(1) The factoresident who is continuous					

			TE SURVEY MPLETED			
		495417	B. WING _		,	C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	•	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690	Continued From pag	e 91	F 6	90		
	maintain continence	services and assistance to unless his or her clinical nes such that continence is ain.				
	ensure that-	on the resident's ssment, the facility must				
	indwelling catheter is resident's clinical cor catheterization was r					
	indwelling catheter o is assessed for remo as possible unless th	nters the facility with an r subsequently receives one wal of the catheter as soon the resident's clinical condition atheterization is necessary;				
	and (iii) A resident who is receives appropriate	incontinent of bladder treatment and services to infections and to restore				
	ensure that a resider receives appropriate restore as much norn possible.					
	and facility documen provide incontinence	view, clinical record review, t review, facility staff failed to care or catheter care for 3 survey sample (Resident		For Resident #34, the physicia notified, order clarified, and 18 cc balloon catheter was inserted secured with a leg strap during process by the licensed nurse. Resident #15, incontinence call	French/10 ed and the survey For	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED		
						С
		495417	B. WING		0:	3/05/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CAPPING	TON PLACE AT RUR	AL DETDEAT		514 NORTH MAIN STREET		
CARRING	ION PLACE AT RUN	AL RETREAT		RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 690	Continued From p	nage 92	F 69	10		
1 000		-	1 08		:	
	The findings inclu	aea:		provided, and the resident w		
	1 The facility ata	ff failed to have the correct		change clothes and take a b		
		ff failed to have the correct I foley catheter size in Resident		tolerated and permitted by R by the Director of Nursing/De		
		have the foley catheter secured		during the survey process. F		
	with a leg strap.	nave the loley catheter secured		#45, the physician and response		
	with a log strap.			were notified by the Director		
	Resident #34 was	readmitted to the facility on		Nursing/Designee regarding		
		ollowing diagnoses of, but not		variance. There was no adve		
		neurogenic bladder, urinary		the resident related to the va		
		mentia, Multiple Sclerosis and		education has been provided	d to current	
	depression. On the quarterly MDS (Minimum staff regarding isolation precaution		autions			
	Data Set) with an	ARD (Assessment Reference		including contact precautions	S	
	Date) of 12/17/18	, the resident was coded as		requirements when entering	the room.	
		rief Interview for Mental Status)		Additional education included	d ensuring	
	score of 7 out of a	a possible score of 15. Resident		that treatment is accurately of	documented	
		ed as requiring extensive		in the clinical record. Reside	nt #45 was	
		aff members for dressing,		provided another trash can o	on or before	
	personal hygiene 2 staff members f	and being totally dependent on or bathing.		04/19/2019.		
				Review and observations ha	ve been	
	On 03/01/19 09:5	5 am, the surveyor observed the		conducted by the Director of		
		ower room. The surveyor asked		Nursing/Designee on or before		
		nursing assistant) #1 if she		04/19/2019 for the following		
		y catheter up so the surveyor		(A) Review of physician □s of		
		ize the foley catheter was in the		resident observations have b		
		picked up foley catheter,		conducted by the Director of		
		t was inserted into the resident,		Nursing/Designee for resider		
		and no gloves on. The size of		current orders for catheters t	-	
		r was observed to be an 18		currently placed catheters ar		
		cc balloon. The Foley catheter freely by the resident's leg and		with the physician □s orders size and balloon size and that		
		a leg strap. The regional MDS		with orders for catheters also		
		et) coordinator was with		physician s orders for a leg		
	1 .	nis entire observation. The MDS		leg strap is in place upon ob		
		d the CNA that the leg straps		(B) Facility rounds, and resi		
	were in Central S			observations have been con-		
				Director of Nursing/Designed	-	
	The surveyor revi	ewed the resident's clinical		wings to ensure that incontin		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET	1 33/03/2010
	Γ			RURAL RETREAT, VA 24368	T
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 690	Continued From pag	ne 93	F 690		
	3/1/19. The surveyor physician order for a with a 5 cc balloon.  The surveyor notified the above document pm in the conference requested and receive policy on Foley catheter will be base justification, and will suprapubic, 3-way), capacity (in cubic ce parameters, as indiction.			provided timely and residents are cleand odor free.  (C) A review has been conducted by Director of Nursing/Designee on or b 04/19/2019 for residents with current orders for antibiotic therapy. The Director of Nursing/Designee will review and compare the current physicians othe the electronic medication administrative record to ensure that physicians order antibiotic therapy have been followed residents with current orders for antilitherapy and that antibiotic treatment been initiated in a timely manner. The SON/Designee will also review the correct for residents currently receiving antibiotic therapy to ensure that treat is accurately documented.  Education has been provided to Lice nurses by the Director of Nursing/Designee regarding ensuring	r the efore ector  r with ion ers for d for biotic has e inical ng ment
	incontinence care to remained clean and 02/28/19 01:34 PM smelled of urine whe and throughout the cis ambulatory and st frequently. The CNA bladder continence t incontinent on 2/27/7 There was a current	The resident and room en surveyors entered on 2/26 day on 2/27/19. The resident aff reported toileting her A documentation listed under hat the resident was not		catheters places are consistent with physician sorder for catheter size a balloon size, catheter care is provide needed, and that leg straps are utiliz secure the catheter. Education has a been provided to licensed nurses regarding following physicians orders antibiotic therapy and implementing antibiotic therapy in a timely manner accurately documenting treatment in clinical record. Inservice education halso been provided to current employ regarding following the required mea and steps when entering the room all providing care for a resident with ord for isolation precautions. Education heen provided to nursing staff by the	the nd d as ed to also s for and the as yees sures nd ers nas

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		PLETED
		495417	B. WING _			1	C 05/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				51	4 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		RU	JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page	e 94	F 6	690			
	the hospital with seps	ITI			Director of Nursing/Designee regarding provision of incontinence care in a time manner and maintaining the resident in clean and odor free condition. Facility rounds, and resident observations will conducted by the Director of Nursing/Designee for three (3) resident total each week for three (3) months for	ely n a be ts or	
	UTI originating in Jan February. Lab orders cultures- no u/a after showed ESBL. Cont- written 2/25 and 2/26 placed on precaution No nursing note to in-	the 2/15 orders. Culture act precaution phone orders . The resident was not s. Sent to ED on 2/28/18. dicate she left the building.			residents with physician sorders for a catheter. These observations will capte both wings and include observing to ensure that the currently placed cathet follows the current physician orders regarding catheter size and balloon size catheter care is provided and that the catheter is secured with a leg strap. Facility Rounds and resident observation will also be conducted by the Director Nursing/Designee throughout the facility and including both wings to total three	er ee, ons of ty (3)	
	tract infection, facility	a timely manner, to ensure vere followed, and to			resident observations weekly for three months to ensure that incontinence ca has been provided and residents are clean, dry, and odor free. Residents th choose to refuse care will have refusal documented in the nurses notes and o	re at	
	1/17/17 with diagnose hypertension, diabeted anxiety, bipolar disord schizophrenia. On the set assessment with 12/24/18 the resident interview for mental se without signs of delirit affecting care.	admitted to the facility on es including heart failure, es mellitus, dementia, der, psychotic disorder, and e quarterly minimum data assessment reference date scored 9/15 on the brief status and was assessed as um, psychosis, or behaviors veyor observed an isolation ent's room. The surveyor			the care plan. The physician and RP walso need to be notified regarding refusion of care and notifications should be documented in the clinical record. A review will be conducted by the Directon Nursing/Designee for three (3) resident weekly for three (3) months and including residents with current orders for antibional therapy. The medical record review will compare the physician sorders with the EMAR to ensure that antibiotic treatments is administered per the physician or and in a timely manner and that treatments.	or of ts e otic II he ent der	

CENTERS FOR MEDICARE & M	MEDICAID SERVICES			Olvii	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		DATE SURVEY COMPLETED
					С
	495417	B. WING	· · · · · · · · · · · · · · · · · · ·		03/05/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	ÞΕ	
CARRINGTON PLACE AT RURAL R	ETREAT		514 NORTH MAIN STREET		
			RURAL RETREAT, VA 24368		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
precautions. The nurse contact isolation for unisolation. On 02/27/19 answered a call light a using gown, glove, or I then retrieved the the I then washed hands ap The surveyor observed the room without donn morning. On 02/28/19 asked the nurse what necessary when visiting that a resident had ES playing in the pee". The meant and she said to surveyor asked if contameant to wear gowns ashe had used the last they had put gowns in day before. She called bring gowns because to The CNA brought a 10 package containing 4 of the cart. 28/19 at 9:30 the resident in the room the surveyor noted the a broken lid which required closed again while PPE. It was difficult to opening the trash can	the resident was on contact the said the resident was on ine, so the room was on at 08:39 AM, a CNA and turned it off without thand sanitizer. The CNA breakfast tray. The aid oproximately 9 seconds. It is at 09:00 AM the surveyor kind of precautions were at the resident. She said BL in urine, so "don't go the surveyor asked what that wear gloves. The act precautions usually and she said that it did, but one. She said she thought the cart at least once the did for a staff member to there were none in the cart. It is pack and a second gowns and placed them in the cart at leaving the room, at trash can in the room had uired 2 hands to open, then the surveyor removed the leave the room without with bare hands.  1/24/19 at 7:36 PM as a late M) "NP notified of ua C&S for contact precautions and as ordered". A telephone 100 mg(milligram)	F 69	is clearly and appropriately de the clinical record. Facility rounds/observations will be of the Administrator/Director of Nursing/Designee for three (3) will include residents with curphysician orders for isolating precautions. The observation include appropriate Director of donning and removal of requiprotective equipment, available personal protective equipment is functional specific to that residents or ocan lid is functional and remateffected resident or ocan lid is functional and remateffected resi	onducted by  B) residents months and rent on s should of Nursing ired personal oility of nt, and that nal and om i.e. trash ins in the ely.  and reviews ctor of r three (3) nce ommittee ciplinary nendations essary to	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
NAME OF PE	ROVIDER OR SUPPLIER	433417	] 3: ::::::0 -	STREET ADDRESS, CITY, STATE, ZIF	P CODE	03/	05/2019
	TON PLACE AT RURAL I	RETREAT		514 NORTH MAIN STREET RURAL RETREAT, VA 24368	0002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 690 F 695 SS=E	than 30 hours after the was given by the nurse. A nurse's note enteredocumented "resident refusing medications Multiple attempts made Shifts. The insulin Madocumented for 9 PM and insulin administratoral medications were administered: Macrol 0.005% eye drops, at 3.125 mg, travatan Z PM medications: depart of the series of	s order was written more e note indicated the order se practitioner (NP).  d 2/26/19 at 4:32 AM t is in a bad mood and is blood sugar checks. de". The nurses work 7-7 AR had N (for see note) I and 10 PM accuchecks ation on 2/25/19. The 9 PM e documented as bid 100 mg, Latanoprost orvastatin 10 mg, carvedilol 0.004% eye drops; and 10 akote 500 mg, timoptic orexa 5 mg, ativan 0.5 mg, It was unclear which used and which were rse was unable to confirm I had been administered that  d director of nursing were ns with urinary tract infection mary meetings on 3/1 and attomy Care and Suctioning	F				4/19/19
	care and tracheal suc care, consistent with practice, the compreh	etioning, is provided such professional standards of nensive person-centered ats' goals and preferences,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NITIMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			C 3/05/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		3/03/2019	
				514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368			
(V4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 695	Continued From page	e 97	F 6	95			
	and 483.65 of this su	bpart.					
	This REQUIREMENT by:	is not met as evidenced					
	,	on, staff interview, facility		For Resident #3, the oxyger	n concentrator		
		d clinical record review, the		flow rate was adjusted by the			
	facility staff failed to p	provide necessary respiratory		nurse during the survey proc	ess to the		
	care and services that	at is in accordance with		appropriately physician order	red flow rate.		
	•	ds of practice, the resident's		The Bi-PAP mask was also s	tored in a		
	•	sident's choice for 4 of 28		plastic bag during the survey			
	-	3, Resident #11, Resident		Resident #3 as well. There w			
	#89 and Resident #3	12).		adverse effects for Resident			
				associated with the oxygen v			
	The findings included	1:		Resident #11, the oxygen ca			
	4 The facility staff fa	iled to coord our control		2/15/19 was changed by other	_		
	_	niled to ensure oxygen was		the survey process. There was adverse effects for the reside			
		ordered amount and failed to Bi-PAP mask in a plastic bag.		Resident #312, the C-PAP m			
	Store Resident #3 5 L	or Al mask in a plastic bag.		cleaned and placed in a plas			
	The clinical record of	Resident #3 was reviewed		bedside in a clean and sanita			
	2/26/19 through 3/5/1			during the survey process. R			
		y 4/5/17 and readmitted		no longer resides in the facili			
		s that included but not limited		3	-,		
	to respiratory failure			The Administrator/Director of	Í		
	hypercapnia, restless	legs syndrome, diastolic		Nursing/Designee have com	pleted		
		orillation, obstructive sleep		medical record/physician ord	er review for		
	apnea, hypokalemia,	constipation, idiopathic		current order and facility rou	nds/resident		
		thy, gastro-esophageal reflux		observations for residents re	-		
		nia, hypothyroidism, major		facility with physician □s orde			
	T	insomnia, anxiety, chronic		oxygen, Bi-PAP and C-PAP t			
		nin D deficiency, benign		review/observations will be o			
		morbid obesity, hypertension,		both wings and include the fo	ollowing		
		ulmonary disease, type 2		criteria:	a⊐a ardara far		
	diabetes mellitus, na	sai congestion, and		<ul><li>(A) Residents with physician oxygen are receiving oxygen</li></ul>			
	migraines.			physician □s ordered flow rat			
	Resident #3's annual	minimum data set (MDS)		(B) Respiratory equipment s			
		assessment reference date		oxygen cannulas not in use,			
		essed the resident with a		Bi-PAP and C-PAP masks wi			
	, ,	for mental status) as 15. No		a plastic bag in a clean sanit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C <b>3/05/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	1001	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP COI		3/05/2019	
INAME OF T	TO VIDER OR OUT FEEL				J.L		
CARRING	TON PLACE AT RURAL	RETREAT		514 NORTH MAIN STREET			
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  CH DEFICIENCY MUST BE PRECEDED BY FULL  SULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5) COMPLETION DATE		
F 695	Continued From pag	e 98	F 6	95			
F 695	evidence of delirium, psychosis. Section of Procedures, and Pro used oxygen while a non-invasive mechar. Resident #3's current dated 2/20/19 read "breathing related to of (diagnosis): COPD (pulmonary disease), failure) and obstructive Approaches: O2 per The surveyor intervie at 11:14 a.m. Reside currently receiving or cannula via oxygen or surveyor also observe the nightstand along were in a bag. Reside always use bi-pap.  The surveyor intervie #5 on 2/27/19 at 11:2 what liter Resident #1.P.N. #5 stated 2 liter maybe somebody but #5 adjusted the amore concentrator.	behaviors affecting others or D Special Treatments, grams assessed the resident resident at the facility and nical ventilation.  It comprehensive care plant have a potential for difficulty chronic conditions-dx chronic obstructive CHF (congestive heart we sleep apnea. Forder, Bi-Pap as ordered."  It was in bed and and and and and and and and and an	F 6	and labeled with the date that changed and replaced with dequipment or cleaned (BiPAI masks).  (C) Residents that require of have their physician sorder ensure that they have a physic outilize oxygen.  (D) Residents with physician oxygen or other respiratory enebs have their respiratory enhanged out and dated per the physician sorder.  Education has been provided employees by the Director of Nursing/Designee with regar following areas:  (A) Oxygen is a medication administered to the resident flow rate per minute. License must adjust oxygen settings considered a medication. Rerequiring oxygen must have sorder to utilize oxygen flow rappropriate for the resident.  (B) Residents with orders for respiratory equipment will have equipment stored in a clean smanner, in a clean plastic bat at the bedside. This includes limited to oxygen cannula, ox Bi-PAP and CPAP masks. Reference in the set of the resident oxygen cannula, ox Bi-PAP and CPAP masks.	xygen use will s reviewed to sician s order ns orders for equipment i.e. quipment ne d to current d to to the and must be at the correct of nurses as it is sidents a physician sate that is a rand utilize ve their and sanitary g and dated but is not kygen mask, espiratory		
	masks. L.P.N. #5 sta stored in a plastic ba	ted, "Masks should be g."		equipment will be replaced a per the physician s order but less frequently than every we	nd/or cleaned at generally no eek.		
	read in part "O2 at 2l	ary 2019 physician's orders _/NC (liters/nasal cannula rn every night at bedtime,		<ul> <li>(C) Medical Record/current order review as well as facilit rounds/resident observations</li> </ul>	У		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	493417	B: Willo _		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019
NAME OF PI	ROVIDER OR SUPPLIER						
CARRING	TON PLACE AT RURAL	RETREAT			14 NORTH MAIN STREET		
				R	RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 99	F6	695			
	document refusals."				conducted by the Administrator/Directo	or of	
					Nursing/Designee throughout the facili		
	The surveyor informe	d the administrator, the			including both wings for a total of three	-	
		e assistant director of			residents per week for three (3) months		
		registered nurse consultant,			The following criteria will be included in		
	and the corporate reg	jistered nurse MDS of the			the weekly review:		
	above concern on 3/1	/19 at 5:34 p.m. The			a. Oxygen is administered at the corr	ect	
	_	is asked if masks should be			physicians ordered flow rate and those		
		g when not in use. The			residents requiring oxygen must have	3	
	DON stated "yes."				physician □s order for the oxygen.		
					b. Respiratory equipment is stored in	а	
The surveyor reviewed the facility policy for				clean, sanitary manner such as plastic			
		gen administration provided			bags labeled at the bed side with the d		
	by the facility on 3/5/1	19.			the respiratory equipment was change out or cleaned. Respiratory equipment		
	The facility policy title	d "Oxygen Administration"			may include but not be limited to oxyge		
		oxygen delivery device so			cannulas, masks, humidification bottle,		
	_	for the resident and the			CPAP/Bi-PAP masks and tubing, and		
		is being administered."			nebulizer masks. Unless otherwise		
	The "CPAP/RiPan Su	pport" policy read in part "1.			specified in a physician sorder, respiratory equipment should be replaced.	har	
	There are general gu				and/or cleaned and labeled every seve		
		ructions are obtained from			(7) days.		
		plier of the PAP device. 7.			(., aa,		
		and tubing: Clean daily by			The results of the interviews and review	NS	
	placing in warm, soap	by water and			will be discussed by the Director of		
	soaking/agitating for				Nursing/Designee monthly for three (3)	)	
	detergent is recomme	ended. Rinse with warm			months at the Quality Assurance		
	water and allow it to a	air dry between uses."			Performance Improvement Committee		
					Meeting (QAPI). The interdisciplinary		
		n was provided prior to the			team (IDT) will make recommendations		
	exit conference on 3/	5/19.			for revisions as indicated necessary to		
	2. The facility staff for	iled to follow the physician			sustain substantial compliance.		
	_	inge the O2 (oxygen) tubing					
	to concentrator and E						
	Tuesday 11-7 for Res						
	. 40044y 11 / 101 1\C3						
	The clinical record of	Resident #11 was reviewed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495417	B. WING _			C <b>03/05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		00.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	admitted to the facili 7/14/18 with diagnos limited to acute resp chronic respiratory fametabolic encephalo muscle weakness, a pain syndrome, type hypertension, anxiet depressive disorder, polyneuropathy, hyp reflux disease, adult schizoaffective disor anemia, dysphagia, disease, urinary tracobstructive pulmona deficiency.  Resident #11's quarassessment with an (ARD) of 2/13/19 as BIMS (brief interview There were no assedelirium, behaviors and the first of the surveyor observation of the surveyor observation and the surveyor observa	19. Resident #11 was ty 2/4/15 and readmitted ses that included but not iratory failure with hypoxia, ailure with hypercapnia, opathy, difficulty in walking, ocute kidney failure, chronic 2 diabetes mellitus, y, hypothyroidism, major bipolar disorder, ockalemia, gastro-esophageal failure to thrive, der, urethral stricture, constipation, Parkinson's oct infection, chronic ry disease, and Vitamin  terly minimum data set (MDS) assessment reference date sessed the resident with a v for mental status) as 15. ssed signs or symptoms of affecting others or psychosis.  ent comprehensive care plan that the resident has an earance related to dx atory failure and dyspnea. r MD (medical doctor) orders.  ved and spoke with Resident tour on 2/26/19 at 1:21 p.m. oxygen was mainly used at ny she was not feeling well.	F	695		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	COMPLETED		
		495417	B. WING		03/05/201	19	
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/201	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	(5) LETION ATE	
F 695	The surveyor was n supply) as the surve room. Other #2 sta duty Sunday, got di Resident #11's tubii one in the building r"I had the same issi resident."  Resident #11's Feb were reviewed. Re orders were oxyger per nc (nasal cannu Change O2 tubing the every week on Tuest The surveyor inform director of nursing, nursing, and the regabove concern on 3	tubing was dated 2/15/19.  The tubing was dated and tubing w	F 69	5			
	store a C-PAP mass manner. Per clinical record r	2 the facility staff failed to k in a clean and sanitary eview Resident #312 was ity on 02/06/19. Diagnoses					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C <b>03/05/2019</b>		
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		90.00.20.00		
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F 695	Continued From pag		F 6	695				
	weakness, essential	(primary) hypertension, oulmonary disease, and sleep						
	admission MDS (mir with an ARD (assess 02/13/19 included a	patterns) of the Resident's nimum data set) assessment sment reference date) of BIMS (brief interview for nary score of 15 out of a						
	initial tour on 02/26/1 observed a C-PAP (opressure) mask for s #312's night stand no 02/27/19 at 10:46am Resident #312, the Othe surveyor on the fine C-PAP mask was surveyor asked Resimask was on the floor	red Resident #312 during 19 at 2:00pm. The surveyor continuous positive airway sleep apnea on Resident ot covered or bagged. On a during an interview with C-PAP mask was observed by floor by Resident #312's bed. as not enclosed in a bag. The dent #312 why his C-PAP or and where was his bag to dent stated "They never put it						
	DON (director of nur #312's C-PAP mask being used. She stat C-PAP mask to be p use. The surveyor re	om the surveyor spoke to the sing) regarding Resident not stored in a bag while not red that she expects the laced in a bag when not in requested a facility policy on storage of respiratory ne.						
	copies of policies/pro Support" and "Infecti	veyor was provided with ocedures titled "CPAP/BiPAP ion Control Guidelines for All '. The policies did not						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495417	B. WING				C 05/2019
	ROVIDER OR SUPPLIER			514	REET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET URAL RETREAT, VA 24368	1 03/	03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page address storage of th		F	695			
		n regarding this issue was y team prior to the exit 19.					
		failed to obtain a physician iinistration of oxygen to					
	1/26/19 with the follow limited to high blood provided failure. On the admisset) with an ARD (As of 2/1/19, the resident extensive assistance dressing and personal was also coded as be	esident #89 was admitted to the facility on 26/19 with the following diagnoses of, but not nited to high blood pressure and respiratory lure. On the admission MDS (Minimum Data et) with an ARD (Assessment Reference Date) 2/1/19, the resident was coded as requiring tensive assistance of 2 staff members for essing and personal hygiene. Resident #89 as also coded as being totally dependent on 2 aff members for bathing.					
		esident #89's room to erview. During this time, erved to be using Oxygen at					
	corporate MDS nurse room. They were me as physical therapy wheelchair. The residuearing oxygen. The surveyor reviewer Resident #89. During could not find a physiadministration of oxygen.	am, the surveyor and the went into the resident's t in the doorway of the room as taking him to therapy in a dent was observed to be d the clinical record of this review, the surveyor cian order for the gen. However, in the nurses' n on 1/26/19, the facility staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495417	B. WING _			1	05/2019
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368	1 00	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	oxygen 2-3 liters/ min  The surveyor notified the above documents pm in the conference the director of nursing order to administer on DON stated, "Yes we requested a copy of the administration of oxygen of the administration of oxygen administration of oxygen Administration "Verify that there is procedure"  At 11 am, the surveyor practical nurse) #1 the resident's care on 3/5. The surveyor asked Lobtain a physician or oxygen. LPN #1 state assumed that there we checking on this first.  At approximately 1:30 interviewed the doctoresidents care. The ophysician's orders an "There is not an order oxygen. He must had him from the hospital.  At 4:20 pm, the surveyor as an "There is not an order oxygen. He must had him from the hospital.	Resident #89 was receiving the by nasal cannula.  the administrative team of ed findings on 3/1/19 at 5:33 froom. The surveyor asked g (DON) if you needed an exygen to a resident. The do." The surveyor he facility's policy on gen.  mately 10:30 am, the copy of the facility's policy for on". The policy read in part, is a physician order for this for interviewed LPN (licensed at was responsible for the 6/19 in the conference room. LPN #1 if you needed to der before administrating ed, "Yes you do. But I was an order without"  O pm, the surveyor or responsible for this doctor reviewed the d progress notes and stated, if for the resident to be given d this when they admitted."	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,
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CARRING	TON PLACE AT RURAL I	REIREAL		RURAL RETREAT, VA 24368	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 695	Continued From page	: 105	F 69	95	
	No further information was provided to the surveyor prior to the exit conference on 3/5/19.				
F 697	Pain Management		F 69	97	4/19/19
SS=D	CFR(s): 483.25(k)				
	provided to residents consistent with profes the comprehensive per and the residents' goard the review, and clinical refailed to provide non-interventions prior to administration for 1 of #362).  The findings included  The facility staff failed non-pharmacological administration of pain 6:18 p.m. for Resident the clinical record of reviewed 2/26/19 throwas admitted to the facility and fibula fracture, head in 2 diabetes mellitus, undisorder, muscle wea encephalopathy, hyperatherosclerotic heart of ischemic attacks), hyperatherosclerotic heart of ischemic attacks.	tre that pain management is who require such services, isional standards of practice, erson-centered care plan, als and preferences. It is not met as evidenced sew, facility document cord review, the facility staff charmacological pain medication for 28 residents (Resident staff).  It to provide interventions prior to the medication on 2/11/19 at the 4362.  Resident #362 was sugh 3/5/19. Resident #362 acility 2/11/19 with led but not limited to left injury, cataract, anemia, type		Resident #362 no longer resides in facility.  Resident interviews will be complete Director of Nursing/Designee for alert/oriented resident swith Brief Interview of Mental Status Score 10 greater to determine what non-pharmacological intervention is effective. A review has been conduct the Director of Nursing/Designee for residents residing in the facility with current physician sorders for as needed/PRN narcotic analgesic medications. The clinical record reviewill acknowledge documentation for previous seven (7) days including progress notes, physician sorders, Electronic Medication Administration Records, and the care plan to identifications requiring non-pharmacologicinterventions prior to utilization of PR narcotic analgesics. The Director of Nursing/Designee will identify potent person-centered non-pharmacologic	d by  or  most ted by  ew the

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
				514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	5-325 tablet take one needed for pain.  The current comprehe 2/21/19 read "I may e to) my recent fracture degenerative disc discare plan did not have approaches for pain redocumented. The caencourage coping me management."  The surveyor reviewer electronic medication (eMARs). Resident # Norco 5-325 mg on 2 that the resident rate read the medication value The surveyor was unnon-pharmacological 2/11/19.  The surveyor informed director of nursing (D registered nurse, and nursing of the above p.m. The DON stated administering prn (white the control of the surveyor was administering prn (white control of the surveyor stated administering prn (white control of the surveyor was administering prn (white control of the surveyor was unnon-pharmacological 2/11/19.	um data set (MDS) yet been completed.  hysician orders were #362 was ordered Norco by mouth every 4 hours as  ensive care plan dated experience pain r/t (related	F 6	interventions for current resident have physician sorders to receneeded/PRN narcotic analgesic medications.  Education has been provided to Nurses by the Director of Nursing/Designee regarding ens non-pharmacological interventio pain management must be attermonitored for effectiveness prior administration of as needed/PRI analgesic pain medication. The nurse must document the pain assessment, the person-centere non-pharmacological interventio attempted for pain management effectiveness prior to administer needed/PRN narcotic analgesic medication to the resident. The Nursing/Designee will conduct of monitoring for a total of three (3) weekly for three (3) months. The of Nursing/Designee will review clinical record including progress Electronic Medication Administrate Record, care plan and physician to identify if non-pharmacological interventions have been identified utilized first, before/prior to admin of as needed/PRN narcotic analymedications. The review will also for appropriate documentation rethe resident spain status, intertreatment and effectiveness.	Licensed suring that ins for inpted and in to in and the ing as in and the ing as in t	-	
	staff are documenting	the non-pharmacological dministration. The surveyor		The results of the interviews and will be discussed by the Director Nursina/Designee monthly for the	r <b>of</b>		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATI 514 NORTH MAIN STREET RURAL RETREAT, VA 243		1 00/00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		_	(X5) COMPLETION DATE
F 697	The surveyor request management.  The surveyor reviewer "Pain-Clinical Protocor physician and staff with have pain or who are The physician will ord non-pharmacologic at a address the individed provide the elements appropriate physical a interventions: for examples of the surveyor request.	atterventions prior to ation in the clinical record. ed the facility policy on pain and the facility policy titled ol." The policy read "1. The ll identify individuals who at risk for having pain. 2. Ider appropriate and medication interventions ual's pain. 3. Staff will of a comforting and	F6	months at the Quality Performance Improve Meeting (QAPI). The team (IDT) will make for revisions as indica sustain substantial co	ement Committee interdisciplinary recommendations ated necessary to	5	
F 698 SS=E	No further information exit conference on 3/5 Dialysis CFR(s): 483.25(l) \$483.25(l) Dialysis. The facility must ensurequire dialysis receiv with professional star comprehensive personal the residents' goals a This REQUIREMENT by:  Based on staff interview, facility staff faci	n."  n was provided prior to the 5/19.  The that residents who we such services, consistent adards of practice, the encentered care plan, and and preferences.  The is not met as evidenced are with the terfor 1 of 28 residents in esident #91).	Fé	Resident #91 no long facility.  A review has been con Director of Nursing/D residing in the facility physician sorders for the state of	onducted by the lesignee for reside that have	ents	/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			1	05/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2013	
					4 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL I	RETREAT			JRAL RETREAT, VA 24368			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 698	Continued From page	e 108	F 69	98				
	Resident #91 was add	mitted to the facility on			The Director of Nursing/Designee has			
	1/31/19 with the follow	ving diagnoses of, but not			reviewed the dialysis communication			
	limited to anemia, atri	al fibrillation, end stage			document for residents receiving dialys	sis		
	renal disease, diabete	es, heart failure and high			services for the previous thirty (30) day	'S		
	blood pressure. On the				regarding accurate and thorough			
		with an ARD (Assessment			documentation/communication betwee	n		
		of 2/7/19, the resident was			the facility and the dialysis center.			
		tensive assistance of 2 staff			E1 -6 1 -1 -1 -1 -1 -1 -1			
		g, and personal hygiene.			Education has been provided to the			
	dependent on 2 staff	o coded as being totally			licensed nurses by the Director of Nursing/Designee regarding ensuring t	hat		
	dependent on 2 stair	members for battling.			the Dialysis Communication Document			
	During the clinical rec	ord review on 3/5/19 at			thoroughly completed with no omitted	13		
		the surveyor requested			information on the document. A review	will		
		nmunication between the			be conducted by the Director of			
	facility and the dialysi	s center. Resident #91			Nursing/Designee three (3) times per			
	goes out to the dialys	is on Monday, Wednesday			week for three (3) months for residents	,		
	and Friday.				residing in the facility receiving dialysis services to ensure that the dialysis			
	The surveyor received	d copies of the			communication document is thoroughly	,		
		s that were requested. The			completed with no omitted information			
	-	ese sheets and noted there			details. Variances/identified concerns v			
		nissing or left blank by the s center. These sheets			be communicated to the Dialysis cente the Director of Nursing/Designee for resolution.	r by		
		the administrative team on			resolution.			
		he conference room. The			The results of the interviews and review	ws.		
		ing) stated, "I will look into			will be discussed by the Director of	.		
	that."				Nursing/Designee monthly for three (3)	,		
					months at the Quality Assurance			
	No further information	n was provided to the			Performance Improvement Committee			
	surveyor prior to the	exit conference on 3/5/19.			Meeting (QAPI). The interdisciplinary			
					team (IDT) will make recommendations			
					for revisions as indicated necessary to			
					sustain substantial compliance.			
F 744	Treatment/Service for	Dementia	F 7	44			4/19/19	
SS=D	CFR(s): 483.40(b)(3)							

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		495417	B. WING			C / <b>05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	03	/05/2019
				514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 744	Continued From pag	e 109	F 74	4		
F / 444	§483.40(b)(3) A resid diagnosed with demonstration his or her hamontal, and psychos This REQUIREMENT by: Based on observation record review, and fafacility staff failed to interventions for 1 of sample (Resident #1 Resident #15 was ac 11/22/15 and readminicluded heart failured disease, psychotic distract infection (UTI), disturbance, dysphagweakness, and difficult quarterly minimum diseasesment references scored 3/15 on the bis status and was assedelirium, psychosis, The assessment indiambulated and used assistance, was frequincontinent, and on a Clinical record review dated 2/10/19 "take of tow and one 0.5 mg order did not give an administration of xamwere limited to 2/10/25.	dent who displays or is entia, receives the at and services to attain or ighest practicable physical, ocial well-being.  T is not met as evidenced  on, staff interview, clinical acility document review, provide behavior-specific 28 residents in the survey 5).  Imitted to the facility on tted on 11/18/18. Diagnoses en hypertension, Alzheimer's asorder, pneumonia, urinary dementia with behavior gia, anxiety, muscle aulty walking. On the atta set assessment with the date 11/15/18, the resident rief interview for mental seed as without symptoms of or behaviors affecting care. Cated the resident the toilet with 1-2 person uently, but not always, a prompted toileting program.  In revealed a physician order one 0.5 mg (milligram) xanax xanax in two hours". The	F 74	For resident #15, specific person-centered targeted behavio been identified and documented. Additionally, non-pharmacologic b specific interventions have also be identified, established, and docum the clinical record for Resident #15.  A review has been conducted by the Director of Nursing/Designee for rewith diagnosed dementia and will the following areas for review:  (A) Clinical record review for residuagnosed with dementia to determ what psychotropic medications the receive what person-centered targe behaviors are specific to each indiversident with dementia, what non-pharmacological interventions as behavior specific interventions been identified, implemented, and documented as well as effectivenes these interventions related to the administration of psychotropic medications.  (B) The review for residents curred diagnosed with dementia will also for appropriate diagnosis and indication or proposition or	ehavior een hented in 5.  he esidents include dents mine ey get ividual s as well have ess of ently observe cation n on	

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		495417	B. WING _			C 03/05/20	119
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE	03/03/20	713
				514 NORTH MAIN STR	REET		
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT,	VA 24368		
(X4) ID PREFIX TAG			ID PREFIX TAG			E COM	(X5) IPLETION DATE
F 744	Continued From page	e 110 r both shifts on 2/10/19.	F 7		ı a progress note detailin	a	
	A nurse's note dated documented "late ent orders received for H now due to increased 5mg/ml given at 13:3 effective results noted aggitated". Haldol did physician order list or administration record indicating the residen the medication admin question" Did Reside this shift?" Was answ on 2/14/19.  The administrative te concerns with psychoreasons for administration.	2/14/19 at 9:25 PM  Try for 2/14/19 13:30: New aldol 5 mg/ml give 5 mg IM I aggitation, IM Haldol 5 without complication, no d RSD only became more d not appear on the on the medication . There were no notes at exhibited behaviors. On histration record, the nt resident exhibit behaviors hered "N" (no) for both shifts  am was notified of the otropic medications, their		why he/she wis medication.  (C) Review wi regarding approsupporting the progress notes medication adr.  (D) Review of targeted behavinterventions a interventions a interventions a interventions a interdisciplinary nurses by the Enursing/Design areas:  (A) Ensuring tidentified and outilization of ps.  (B) Ensuring tidentified and outilization of ps.  (B) Ensuring tidentified and outilization of ps.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.  (C) Ensuring tidentified and coumented in including the ca.	shes to continue the sill include verification repriate documentations targeted behavior in the sor on the electronic ministration record. It care plan to ensure the viors, the behavior-specified non-pharmacological are listed on the care plan been provided to the y team and the licensed Director of the regarding the following that targeted behaviors a documented for the sychotropic medications. That non-pharmacologic, the dehavior specific have been identified and the clinical record are plan. That effectiveness of logic, behavior specific is documented in the clinical second are documented in the clinical second in the clinical secon	fic  n.  ng  ure  cal  y  for  s: for  ved	

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		495417	B. WING _			03/	05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL I	DETDEAT			TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET		
CARRING	ION PLACE AT RURAL I	RETREAT		R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755 SS=F	CFR(s): 483.45(a)(b)( §483.45 Pharmacy So The facility must providrugs and biologicals them under an agreer §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accurated	eedures/Pharmacist/Records 1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed		744	of these medication and that these behaviors and non-pharmacologic behavior specific interventions have be documented.  (B) The physician sorders for as needed/PRN, psychotropic medications include a fourteen (14) day timeframe fouse until the resident can be re-evaluated by the physician for continued utilization the medication.  The results of the interviews and review will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.	s or ed n of vs	4/19/19

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		495417	B. WING			03/	05/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE AT RURAL	RETREAT		5	14 NORTH MAIN STREET			
CARRING	TON FLACE AT NONAL	KLIKLAI		R	RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	must employ or obtain pharmacist who-  §483.45(b)(1) Provide aspects of the provision the facility.  §483.45(b)(2) Establisher eceipt and disposition sufficient detail to ensure conciliation; and  §483.45(b)(3) Determination or expected and that an account is maintained and performation or expected and performance in the provided and performance in	consultation. The facility in the services of a licensed ses consultation on all ion of pharmacy services in shes a system of records of on of all controlled drugs in able an accurate ship in able an accurate ship in a count of all controlled drugs riodically reconciled. If is not met as evidenced son, staff interview, clinical icility document review, provide safe medication and to keep medications tration on 5 of 6 medication residents in the survey 110, 34, 45, 72, and 17.  It:  failed to provide safe in 5 out of 6 medication carts  4:25 pm, the surveyor in the drawers for the 500 art:	F	755	The loose pills identified in the drawers 500 hallway med cart on 2/26/19 at 4:2 pm, 600 hallway med cart on 2/26/19 at 4:45 pm, 200 hallway med cart drawers on 2/26/19 at 6:02 pm, 100 hallway med cart drawers on 2/26/19 at 6:00 pm have been removed and discarded by the Director of Nursing/Designee during the survey process. The Besivance sus 0.6 eye drops with the opened date 9/21/13 identified on the 500-hallway med cart were discarded by the Director of Nursing/Designee during the survey proves. Levemir insulin identified on the 500-hallway med cart with no opened on the vial was discarded by the Director of Nursing/Designee during the survey	t t s d ve e 6% 8		
	" (1) Black capsule " (1) med. round p " (1) pink med pill " (4) white oblong	oill yellow			process. The Latanoprost sol 0.005% identified on the 300-hallway med cart with no open on them at 5:37 pm on 2/26/19+ were discarded by the Director	or		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			03/	05/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON DI ACE AT DUDAI	DETDEAT		5′	14 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	REIREAI		R	URAL RETREAT, VA 24368		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 755	Continued From pag	e 113	F	755			
				00	of Nursing/Designed during the survey		
	<ul><li>(1) orange caps</li><li>4 white med pills</li></ul>				of Nursing/Designee during the survey process. There were no adverse effect		
	" 1 yellow large pi				for residents related to the documented		
	" 1 blue oblong pi				areas identified on the medication carts		
	" 1 small round pi				Resident #110 no longer resides in the		
	" 1 pink round sm				facility. For Resident #72, the physiciar		
	" 1/2 LARGE whit				and the responsible party were notified		
	" 1 orange round	•			regarding the variance for the Gentian		
	" 1 small white pil	•			Violet 1%. There were no adverse effective	cts	
		0.6% 9/21/18 eye drops			for the resident related to the variance.		
		18 but not discarded after			For Resident #17, the physician and th	e	
	30 days				responsible party were notified by the		
		had no opened date on the			Director of Nursing/Designee regarding	1	
	vial	•			the variances for the following	<b>^</b>	
					medications and dates:		
	1(b). At 4:45 pm, the	surveyor observed the			(A) 2/27/19 at 9:00 pm Zatador and		
	following in the 600 h	nallway medication cart			Seroquel not administered, not available	le	
	drawers:				(B) 2/28/19 at 9:00 am Zatador, Mobio	<b>;</b> ,	
	" 1 small orange p	pill			Propylene glycol eye drops not		
	" 1/2 pink med roເ	und pill			administered, not available		
	" 1 blue oblong pi				There were no adverse effects for		
	" 1 large oblong y				Resident #17 related to the variances		
	" 1/2 sm. purple o				identified medications are available as		
	" 1/2 blue oblong	pill			ordered by physician for administration		
					For Resident #45, medications including	g	
		surveyor observed the			Ativan are available for administration.		
	- <del>-</del>	nallway medication cart			The physician and responsible party we	ere	
	drawers:				notified by the Director of		
	" Latanoprost sol	0.005% no open date on it			Nursing/Designee regarding the varian		
	4/1) 4/0.00 #				for the Ativan identified as detailed belo		
		e surveyor observed the			(A) 2/27/19 □ Ativan 0.5 mg not availa	e	
	- <del>-</del>	nallway medication cart			at 10 am and 2 pm	-1-	
	drawers:	Jana aanaula			(B) 2/28/19 □ Ativan 0.5 mg no availal	bie	
	i teal colored of				at 10 am and 2 pm	_	
	i biowii iodiid p				(C) The resident took her last Ativan o	11	
	i illed willite fot	1 med whilte round pill			2/26/19 There was no indication that Ativan was		
	2 write obloring p					S	
	i Siliali loullu wi				obtained, received, or codes were	h a	
	" 1/2 white pill rou	na			obtained by the licensed nurse to use t	ne	

Facility ID: VA0414

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG		С		
		495417	B. WING				05/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON DI ACE AT DUDAI	DETDEAT		51	14 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		R	URAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
IAG			IAO		DEFICIENCY)			
F 755	Continued From no	no 111						
F 733	Continued From pag			755				
	" 1 small round to	an pill			back up supply to administer the Ativar 2/27 and 2/28 at 10 pm even though	on		
	1(a) At annrovimate	ely 6:05 pm, the surveyor			these doses were documented as			
		ng in the drawers of 100			administered. For Resident #34 there v	ıas		
	hallway medication				no information or details listed on the	, uo		
	" 1 white capsule				2567 for F755.			
	" 1 yellow and bla				200. 10. 1 7 00.			
	" 1 small pink rou	- ·			For current residents residing in the			
	" 1 orange capsu				facility, the Director of Nursing/Designe	е		
	" 1 med round wh				conducted a Medication Administration			
	The surveyor notifie	d the director of nursing			Record to medication cart review to			
	(DON) and the corp	and the corporate nurse of the above			ensure that medications ordered and			
	documented findings	s on 2/26/19 at 6:30 pm.			listed on the Medication Administration			
	The surveyor notifie	d the administrative staff of			Record were available on the medication	on		
	the above documen	ted findings on 3/5/19 at 4:20			carts for both wings.			
		sked the director of nursing						
		ions were to be stored and			Education has been provided to license	ed		
	labeled once they w	ere opened. The DON			nurses by the Director of			
		nedication is opened, the			Nursing/Designee regarding the followi	ng		
		nent the date in which it was			areas:			
	•	the medication after 30 days.			(A) Procedures □ a facility must provid	de		
		kept in the cards and in the			pharmaceutical services (including			
		n not administering them. If			procedures that assure the accurate			
		in the drawers of the med			acquiring, receiving, dispensing, and	4-		
	· ·	dispose of medications			administering of drugs and biologicals) meet the needs of the residents.	το		
	appropriately."							
	No further information	on was provided to the			<ul><li>(B) When the licensed nurse identifies that a medication is unavailable for</li></ul>			
		on was provided to the exit conference on 3/5/19.			administration per the physician order,	tho		
	Surveyor prior to trie	exit conference on 3/3/19.			licensed nurse will contact the physician			
	2. The facility stat	ff failed to ensure a			responsible party, the pharmacy and the			
		ilable at the time of the			Director of Nursing/Designee at that tin			
		ration for Resident # 110.			so that assistance may be provided to	.5		
		2.2 101 1.001.001.11 110.			obtain the medication.			
	The facility staff faile	ed to follow physician orders			(C) A weekly verification will be complete	eted		
		n of an antibiotic to Resident			for three (3) months by the Director of			
	#110.				nursing/Designee to observe the			
		admitted to the facility on			Medication Administration Record and			
		wing diagnoses of, but not			verify that medications are available on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			,	c	
		495417	B. WING _				05/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON DI ACE AT DUDAI	DETDEAT		51	4 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	REIREAI		Rl	URAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 755	organism. On the act Data Set) with an AR Date) of 1/14/19, the having a BIMS (Brief score of 9 out of a possible score of 9 out of	gh blood pressure, UTI and multidrug resistant Imission MDS (Minimum ID (Assessment Reference resident was coded as Interview for Mental Status) possible score of 15. Resident I as requiring extensive members for dressing and cord review from 2/26/19 urveyor noted that the I to have Vancomycin 500 D days. This order was strated by the facility staff on On the detail section of the lication Administration I 2019, the following was I 3/19 (Scheduled for 2/23/19 available from pharmacy. I Scheduled for 3/2/19 at 9:00 ng pharmacy arrival" If the administrative team on the conference room. In was provided to the exit conference on 3/5/19. Ithe facility staff failed to on Gentian Violet 1% was tration for six consecutive	F 7	755	the medication cart as ordered by the physician and as listed on the Medicati Administration Record.  Necessary measures to ensure that medications are available for administration as ordered include the following:  (A) A weekly verification will be compl for three (3) months by the Director of Nursing/Designee to observe the Medication Administration Record and verify that medications are available or the medication cart as ordered by the physician and as listed on the Medicati Administration Record.  (B) A random weekly review/observati will be completed by the Director of Nursing/Designee for three (3) resident on each wing for a total of six (6) residents weekly for three (3) months the ensure that the medications available of the medication cart are consistent with physician sorders and the medication administration record.  The results of the interviews and review will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.	eted  ion ion ts o on the n ws		
		view Resident #72 was y on 02/16/17. Diagnoses						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	I	03/03/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 755	chronic obstructive obesity, difficulty we obesity, difficulty we section C (cognitive annual MDS (miniman ARD (assessmeincluded a BIMS (besummary score of a Resident #72's conceviewed and contained and often have modamage". The interlimited to, "Medicate as ordered".  Resident #72's clin 02/26/19 at 05:29 porder contained an read in part "Gentiat tongue and cheeks total". The Resident medication administof February was reentries marked "N" unavailable for adm 10 pm; 02/22/19 at 02/23/19 at 6 am ardocumentation was administration recoon 2/21/19 at 9:57	nited to diabetes mellitus, pulmonary disease, morbid alking, and muscle weakness.  e patterns) of the Resident's num data set) assessment with ent reference date) of 01/14/19 rief interview for mental status) 15 out of a possible 15 points.  In prehensive care plan was ained a problem area for oreakdown related to impaired inenceI am morbidly obese isture associated skin eventions included but were not ions as ordered. Treatments  ical record was reviewed on m. Resident #72's physician's order dated 02/20/19 which an Violet 1% solution apply to three times a day for 3 days t's eMAR (electronic stration record) for the month viewed and contained an indicating the medication was ninistration on 02/21/19 at 6am, 2pm, and 10pm; and 2pm. The following is reviewed under rid "details" which read I part: pm "Gentian Violet 1%	F 75	55			
	arrived new order"; Violet 1% solution	d for 2/21/19 10:00pm has not 02/22/19 3:57am " Gentianscheduled for 2/22/19 6:00am pharmacy at this time"; "Gentian Violet 1%					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495417	B. WING		03/05/2019		
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 755	from pharmacy"; 02/1% solutionscheduled unavailable"; 02/23/3 solutionscheduled administered".  The surveyor spoke on 02/27/19 at 3:13p. Resident #72's mediadministration.  No further information provided to the surveyor conference on 03/054. For Resident #17 medications were available to the surveyor spoke on 02/27/19 at 3:13p. Resident #17b. The surveyor spoke on 03/054. For Resident #17 medications were available to the surveyor spoke on 03/054. For Resident #17 was ac 4/19/16. Diagnoses gastroesophageal remellitus, anxiety, depronic pain. On the assessment reference scored 15/15 on the status and was assed delirium, psychosis, Medication orders in one tablet by mouth eye drops one drop of Seroquel 50 milligration bedtime, and propyletimes a day.	for 2/22/19 2:00pm, e new order when available 22/19 5:12pm "Gentian Violet aled for 2/22/19 10:00pm, 19 4:12am "Gentian Violet 1% for 2/23/19 6:00am was not with the administrative team om regarding the concern of cation not being available for on regarding this issue was ey team prior to the exit 1/19. If facility staff failed to ensure railable for administration. Included hypertension, and the annual assessment with the date 2/7/17, the resident brief interview for mental assed as without signs of or behaviors affecting care.  Cluded Mobic 7.5 milligram daily started 1/10/19, Zatador each eye twice a day, ms one tablet by mouth at ene glycol 1 drop each eye 4	F 75				
	_	d review on 2/28/19, the on 2/27/18 at 9 PM Zatador documented as "not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG	(C	(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	)E	33/33/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			ENCED TO THE APPROPRIATE		
F 755	AM Zatador, Mobic, drops were documer meds not available".  Nursing staff were use for four physician or unavailable to admir.  The administrator ar notified of the conce during a summary medical for administration.  Resident #45 was real/17/17 with diagnosty hypertension, diabetty, bipolar disors schizophrenia. On the set assessment with 12/24/18 the residenty interview for mental without signs of deliral affecting care.  During clinical record a physician order wrong (milligram) by medical maxiety. 2/27/19 Attanvailable for the 10 2/28/19 for the 10 All medication administration.	and propylene glycol eye and propylene glycol eye and as "not administered- mable to offer an explanation dered medications being distration.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indidirector of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician notification deeting on 3/1/19.  Indicate of nursing were arms with physician	F 7	755			
	2/27 and 2/28. It was administered on 3/1	s documented as at 10 AM and 2 PM. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			(	С
		495417	B. WING _			03/	05/2019
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE  14 NORTH MAIN STREET  URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 SS=D	her last ativan on 2/26 indication in the notes the ativan. 03/01/19 discussed the issue with She offered to investicalled the physician at a code to allow her to the backup supply. Sithat the nurse had reconstructed backup supply to admon 2/27 or 2/28 at 10.  On 3/1/19, the admining were aware the for administration on the 10 PM doses had administered on those Drug Regimen is Free CFR(s): 483.45(d)(1)-\$483.45(d) Unnecess Each resident's drug unnecessary drugs. Adrug when used-\$483.45(d)(1) In exceeduplicate drug therap \$483.45(d)(2) For exceeduplicate drug therap \$483.45(d)(4) Without use; or	ted that the resident took 6/19. There was no a that the nurse had received 03:20 PM. The surveyor with the Director of Nursing. It is gate whether the nurse had and the pharmacy and gotten obtain the medication from the did not obtain information believed codes to use the hinister ativan to the resident PM.  It is strator and director of the national ativan was unavailable 2/27 and 2/28/19 and that been documented as the dates. It is from Unnecessary Drugs (6)  It is programment to the resident PM.  It is strator and director of the national and the pharmacy and gotten and the phar		755			4/19/19

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495417	B. WING _		C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 757	Continued From page reduced or discontinued §483.45(d)(6) Any constated in paragraphs section.  This REQUIREMENT by:  Based on staff intervereview, and clinical refailed to ensure 2 of 2 unnecessary medical Resident #64).  The findings included 1. The facility staff facorder for medication #11. Resident #11 refooding (milligrams) is ordered.  The clinical record of 2/26/19 through 3/5/2 admitted to the facility 7/14/18 with diagnost limited to acute respice chronic respiratory facility metabolic encephalo muscle weakness, according to the second of the sec	e 120 Judy or	F 7	For Resident #11, the physician and responsible party were notified by the Director of Nursing/Designee of the medication variance with Keflex. Ther were no adverse effects for the resider related to the medication variance. For Resident #64, the physician and the responsible party were notified by the Director of Nursing/Designee of the variance with Macrodantin from 12/20 through 12/27/18. There were no adveffects for the resident related to the medication variance.  The Director of Nursing/Designee has conducted a review to verify that antity medications have been administered ordered by the physician. The Director Nursing/Designee has reviewed the Electronic Medication Administrator Records as well as the physician sorders for the previous thirty (3) days	the re ent or o/18 erse Solotic as or of
	depressive disorder, polyneuropathy, hyporeflux disease, adult schizoaffective disordanemia, dysphagia, disease, urinary tract	r, hypothyroidism, major bipolar disorder, okalemia, gastro-esophageal failure to thrive, der, urethral stricture, constipation, Parkinson's		residents with physician sorders for antibiotic medications to identify furthwariances requiring correction and notification to the physician and responsible party.  Education has been provided to the licensed nurses by the Director of Nursing/Designee regarding the six (6 rights of medication administration,	er

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	3			
		495417	B. WING			C 03/05/2019	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•		
				514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 757	Continued From pag	e 121	F 75	57			
				administering medications as	s ordered by		
	Resident #11's quart	erly minimum data set (MDS)		the physician and the regular	-		
	assessment with an	assessment reference date		requirements that state each	resident⊡s		
	(ARD) of 2/13/19 ass	sessed the resident with a		drug regimen must be free fr	rom		
	BIMS (brief interview	for mental status) as 15.		unnecessary drugs. This incl	ludes		
		ssed signs or symptoms of		medication in excessive dose			
	delirium, behaviors a	ffecting others or psychosis.		excessive duration. Ongoing	_		
				and review will be conducted	•		
		ted 12/10/18 read "1. Keflex		Director of Nursing/Designed	-		
		n) qid (four times a day) x 10		three (3) residents for three (			
	days for infected ingrown toenail. 2. Consult podiatry."			The Director of Nursing/Desi review physicians□ orders a			
poun	podiatry.			to the Electronic Medication	na comparc		
	A review of the Dece	mber 2018 electronic		Administration Record for thr	ree (3)		
		ation record (eMAR) had		residents with orders for anti	` '		
	documentation that k	The state of the s		medications to ensure that m	nedications		
	administered 41 dose	es. The physician order was		are administered as ordered	by the		
	for 40 doses.			physician. The review will ve	rify that no		
				excessive doses were admir			
	· -	ed the corporate registered		notification to the physician a			
		oncern on 3/4/19 at 5:45		responsible party are comple			
	p.m.			further variances identified a			
	On 3/5/10 the serve	rate RN stated the first dose		documented in the clinical re	ecora.		
	· ·	ne facility stat box and was		The results of the interviews	and reviews		
		tal amount. The "Starter Kit		will be discussed by the Dire			
	I .	orm" for 12/10/18 indicated		Nursing/Designee monthly for			
		2) were removed by licensed		months at the Quality Assura			
		12/10/18 at 4:00 p.m.		Performance Improvement C			
				Meeting (QAPI). The interdis	ciplinary		
		he surveyor informed the administrator, the		team (IDT) will make recomm			
	director of nursing, the assistant director of			for revisions as indicated neo			
		e registered nurse, the		sustain substantial compliand	ce.		
	regional executive, and the corporate MDS						
	_	ne above concern on 3/5/19					
	at 4:26 p.m.						
	The surveyer reviews	ad the facility policy titled					
		ed the facility policy titled cations" on 3/5/19. The					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	' '	DATE SURVEY COMPLETED
		495417	B. WING			C <b>03/05/2019</b>
	ROVIDER OR SUPPLIER	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 757	policy read in part "F is a physician medic procedure."  No further informatic exit conference on 3  2. The facility staff a mg (milligrams) to R (6 doses) after the u bacteria (Enterobact and 7 days with a cu the medication.  The clinical record of 2/26/19 through 3/5/ admitted to the facilit that included multiple infection, gastro-eso chronic pain, major of weakness, difficulty hyperactivity disorder Vitamin deficiency. Resident #64's quar (MDS) assessment reference date (ARE resident with a BIMS status) as 15/15. Re signs or symptoms of affected others or ps  A telephone order day	Preparation 1. Verify that there ation order for this  on was provided prior to the /5/19.  administered Macrodantin 100 esident #64 for 3 extra days rine culture showed the er Cloacae) was resistant alture showing resistance to  f Resident #64 was reviewed 19. Resident #64 was ty 12/18/15 with diagnoses e sclerosis, urinary tract phageal reflux disease, depressive disorder, muscle in walking, attention-deficit err, overactive bladder, and terly minimum data set with an assessment of 2/6/19 assessed the 6 (brief interview for mental esident #64 had no assessed of delirium, behaviors that	F 75			
	100 mg bid (twice a to 16 Fr (French) wit balloon."	day) x 7 days, change Foley h 5 cc (cubic centimeters)  red the urine culture results. sults showed Resident #64				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	<b>.</b>	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	culture results were received Resident #64 received Macrodantin after the The urine culture was practitioner on 12/26/Macrodantin bid on 13/2/27/18 at 9:00 a.m.  The surveyor interviet nursing and the facilititis 3/5/19 at 3:18 p.m. The ADON the urine cultur 12/23/18. When asket the physician when the 12/23/18 showing the (Macrodantin) was read ADON stated, "Nurse plate when an antibiod Resident #64 received days or 14 doses for that the results review resistant to the medical The assistant director preventionist stated simulation ordered to urinary tract infection bacteria.  The surveyor informed director of nursing, the corporate regional executive, are regional executive, are regional executive, are received assistant executive, are surveyor and the surveyor and the surveyor are gional executive, are regional executive, are regional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor are gional executive, are received as a surveyor and the surveyor	urrent medication toin (Macrodantin)]. The eturned on 12/23/18. d seven (7) more doses of culture result on 12/23/18. reviewed by the nurse 18. Resident #64 received 2/26/18 and one dose on  wed the assistant director of y's infection preventionist on the surveyor showed the re results obtained by ed if the nurses should notify the culture came back on antibiotic currently ordered sistant to the bacteria. The sened to step-up to the tic ordered is resistant."  d Macrodantin 100 mg for 7 the urine culture/sensitivity and the bacteria was ation.  of nursing/infection the didn't identify that the the treat Resident #64's the administrator, the the assistant director of the registered nurse, the and the corporate MDS the above concern in the end	F 7	757		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	exit conference on 3/5 Free from Unnec Psy	n was provided prior to the 5/19. chotropic Meds/PRN Use		757 758			4/19/19
SS=E	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compreheresident, the facility management of the compreheresident, the facility management of the clinical record;  §483.45(e)(1) Reside psychotropic drugs and unless the medication specific condition as continuous in the clinical record;  §483.45(e)(2) Reside drugs receive gradual behavioral intervention contraindicated, in and drugs;  §483.45(e)(3) Reside psychotropic drugs pounless that medication diagnosed specific continuous in the clinical record;	ppic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following  ensive assessment of a nust ensure that ints who have not used the not given these drugs in is necessary to treat a diagnosed and documented  ints who use psychotropic dose reductions, and ins, unless clinically interfort to discontinue these  ints do not receive fursuant to a PRN order in is necessary to treat a andition that is documented					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/03/2013	┪
				514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 758		. Except as provided in	F 75	8		
	beyond 14 days, he o	er believes that it is RN order to be extended or she should document their ont's medical record and				
	drugs are limited to 1 renewed unless the a prescribing practitione the appropriateness of	ttending physician or er evaluates the resident for				
	Based on staff interv review, and clinical re failed to ensure 7 of 2 unnecessary psychot #3, Resident #11, Re Resident #70, Reside	iew, facility document cord review, the facility staff 18 residents were free of an ropic medication (Resident sident #15, Resident #36, ant #101, and Resident point identified resident specific entified.		Resident #362 no longer resides in the facility. For Resident #11, person-cent specific targeted behaviors have been identified and documented in the clinic record including the care plan by the Director of Nursing/Designee for use of psychotropic medications that include Buspirone, Effexor, Trazodone, Geodand Valproic Acid. For Resident #3,	ered al of	
				person-centered specific targeted behaviors have been identified and documented in the clinical record including the care plan by the Director Nursing/Designee for use of psychotromedication that include Duloxetine an Trazadone. Resident #101 no longer	pic	
	was admitted to the fa diagnoses that includ fibula fracture, head i 2 diabetes mellitus, u disorder, muscle wea	ough 3/5/19. Resident #362 acility 2/11/19 with ed but not limited to left njury, cataract, anemia, type		resides at the facility. For Resident #3 person-centered targeted behaviors h been identified, documented and monitored in the clinical record by the Director of Nursing/Designee for the u of psychotropic medication that includ Xanax. For Resident #15, specific person-centered targeted behaviors h	se es	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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				514 NORTH MAIN STREET		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 758	Continued From pag	e 126	F 75	8		
	atherosclerotic heart ischemic attacks), hy disc degeneration of edema. The admission minin assessment had not The February 2019 previewed. Resident mg (milligrams).  The surveyor reviewed comprehensive care care plan read, "I have anxiety/depression." behaviors. There we behaviors or non-phadocumented.  The current comprehe 2/21/19 read "I have secondary to physical There were no identification-pharmacological and related to) psychotrotake Zoloft for a diago bipolar disorder, anx Interventions: Monito qshift (every shift). Swere documented but the discontinuous mining the secondary to the proper secondary to the secondary to t	disease, TIA (transient rperlipidemia, intervertebral lumbosacral region, and num data set (MDS) yet been completed.  shysician orders were #362 was ordered Zoloft 100  ed the current plan dated 2/21/19. The		been identified and documented clinical record including the care the Director of Nursing/Designee Additionally, non-pharmacologic interventions have been identified implemented and documented in clinical record including the care the Director of Nursing/Designeer regarding the variance with Xana 2/10/19 and Haldol on 2/14/19. The were no adverse effects for their related to the variance.  A review has been conducted by Director of Nursing/Designee for with physician or orders for psycomedications to include the follow areas:  (A) Person-centered specific tabehaviors have been identified a documented I the clinical record the care plan.  (B) Non-pharmacological behave specific interventions have been implemented and documented in clinical record including the care (C) Effectiveness of intervention monitored and documented in the record (D) Psychotropic medications a administered for specific targete behaviors only and there is docuindication for use of the psychotre education (i.e. in the physician progress note, care plan, Electors.)	plan by e. al d, n the plan b e. ax on There resident  the residents chotropic ring rgeted including  vior identified, n the plan. ns is is clinical are d imented ropic s order,	
	The surveyor informed director of nursing (D	ed the administrator, the iON), the corporate		Medication Administration Recor (E) Appropriate diagnosis and if for use of the psychotropic medi	d etc.) ndication cation. As	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	I' '		(X3) DATE COMP	SURVEY LETED
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				RI	URAL RETREAT, VA 24368		
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F 758	Continued From page	e 127	F 7	758			
F 758	nursing of the above op.m. The DON was a know what behaviors Zoloft. The DON stat was not specific for Z Staff have a drop dow they can choose from psychological sympto. The surveyor request psychotropic medicat for Resident #362's ta The surveyor reviewe "Behavioral Assessm Monitoring" on 3/1/19 "Management:  2. The care plan will incomprehensive asses with current standard:  7. Interventions will be an overall care environ physical, functional as strives to understand, resident's distress or  8. Interventions and a detailed assessmer and behavioral sympticauses, as well as the environmental reason care plan will include, description of the behavioral mental reason care plan will include, description of the behavioral and/or psychological and/or psychological strives.	concern on 2/27/19 at 3:04 asked how does the staff are being targeted for ed that behavior monitoring oloft; it's for the entire shift. In list when charting where In the full array of Ins.  ed the facility policy on ions and the drop down box argeted behaviors.  ed the facility policy titled ent, Intervention, and Intervention, and Intervention and Intervention and Intervention and part of Insert and be consistent Insert and be consistent Intervent or relieve the It is of care. Intervention and part of Insert and part	F 7	758	have a 14-day restriction on tire frame administration unless the physician has re-evaluated use of he medication and documented rationale in a progress no specifying the details of why he/she wishes to continue us of the medication (F) Review verified that there is appropriate documentation that support the targeted behavior or use of medica in the clinical record including progress notes, Electronic Medication Administration Record, care plan.  Education has been provided by the Director of Nursing/Designee to Licens Nurses regarding the following areas:  (A) Regulatory guidance for psychotrodrugs: A psychotropic drug is any drug that affects brain activities associated wental processes and behavior. These drugs include but are not limited to drug in the following categories: antipsychot anti-depressant, anti-anxiety and hypnomatic-depressant, anti-anxiety and hypnomatic-depressant, the facility must ensure the 1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessare to treat a specific condition as diagnose and documented in the clinical record; Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinical contra-indicated, in an effort to discontinue use of these drugs; 3) Residents do not receive psychotropic	te  n.  ts tion  ed  ppic  with  gs ic, ptic.  nt  nat  ary  ed  2)	
		vention and approaches. d.  sble goals for targeted  e staff will monitor for			drugs pursuant to a PRN/as needed or unless that medication is necessary to treat a diagnosed specific condition that		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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				R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	effectiveness of the in 9. Non-pharmacologic to the extent possible of antipsychotic medibehavioral symptoms 10. When medication behavioral symptoms rationale for use, potential risks and be discussed with the retarget behaviors and dosage, duration, modures consequent dose reduction.  The DON provided a down box (special repsychotropic medical "Special Requirement a drop down box for following behaviors with down box that staff con This was not personbox included throwing smearing bodily was other-see nurses not self, scratching self, psexual acts, hitting, k grabbing, sexually at screaming, and cursis the drop-down box and No further information exit conference on 3/2. The facility staff facility sta	ntervention. c approaches will be utilized to avoid or reduce the use ications to manage s. as are prescribed for s, documentation will include tential underlying causes of pproaches and interventions of antipsychotic medications, tenefits of medications as tesident and/or family, specific texpected outcomes, to initoring for efficacy and tes, and plans for gradual  "screenshot" of the drop quirements) used for tion targeted behaviors. The tot Type (View Only)" included "Behavior Types." The tot Type (View Only)" included "Behavior Types." The total The drop down to g food, smearing food, tes, disruptive sounds, tes, disruptive sounds, tes, disrobing in public, hitting to acing, rummaging, public ticking, pushing, scratching, to busing, threatening, the resident specific.  The was provided prior to the to avoid or reduce the use to avoid or reduc	F	758	documented in the clinical record; and PRN/as needed orders for psychotropic drugs are limited to 14 days unless the attending physician or practitioner determines that it is appropriate for the PRN/as needed order to be extended beyond the 14 days, he or she should document their rationale in the resident medical record and indicate duration fo the as needed/PRN order. Finally, PRN orders for anti-psychotic drugs are limit to 14 days and cannot be reviewed unlet attending physician or prescribing practitioner evaluate the resident for the appropriateness of that medication.  (B) Facility staff must ensure that targe behaviors are identified and documente for the utilization of psychotropic medications.  (C) Facility staff must ensure that non-pharmacologic, person-centered behavior specific interventions have be identified, implemented and documente in the clinical record including but not limited to the care plan.  (D) Facility staff will monitor the effectiveness of non-pharmacologic, behavior-specific interventions and enseffectiveness is documented in the clinical record as well.  The Administrator/Director of Nursing/Designee will conduct a weekly review for three (3) residents per week three (3) months for the following areas (A) Residents with physician or eview to ensure that person-centered targeted behaviors are identified and documented in the clinical record including but not in the clinical record including but not on the clinical rec	ess e eted en ed for for for for for for ded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495417	B. WING _			03	/05/2019	
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				514	4 NORTH MAIN STREET			
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F 758	Continued From p	age 120	E 7	758				
1 700	-	-	F /	36	limited to the consulting			
		tropic medications for Resident			limited to the care plan.			
	#11. 				(B) Non-pharmacological behavior-specific interventions have be	non.		
	The clinical record	of Resident #11 was reviewed			identified, implemented and documented			
		/5/19. Resident #11 was			in the clinical record including but not	Ju		
		cility 2/4/15 and readmitted			limited to the care plan.			
		loses that included but not			(C) Effectiveness of interventions is			
		spiratory failure with hypoxia,			monitored and documented in the clinic	cal		
	chronic respiratory failure with hypercapnia,				record.			
	metabolic encepha	alopathy, difficulty in walking,			(D) Psychotropic medications are only	,		
		, acute kidney failure, chronic			administered for specific targeted			
		pe 2 diabetes mellitus,			behaviors and there is documented			
	hypertension, anxi			indication for use of the psychotropic				
		er, bipolar disorder,			medication (i.e. in the physician ☐s orde	ers,		
	' ' '	ypokalemia, gastro-esophageal			progress note, care plan, electronic			
	reflux disease, add	order, urethral stricture,			medication administration record.) (E) Appropriate diagnosis and indication	on		
		a, constipation, Parkinson's			for use of the psychotropic medication,			
		act infection, chronic			needed/PRN psychotropic medications			
		nary disease, and Vitamin			have a fourteen (14) day restriction on			
	deficiency.	,			time frame for use unless the physician			
	•				has re-evaluated use of the medication			
	Resident #11's qua	arterly minimum data set (MDS)			and documented rationale in the progre	ess		
		an assessment reference date			note specifying the details as to why			
		assessed the resident with a			he/she wishes to continue us of the			
	,	ew for mental status) as 15.			medication.			
		sessed signs or symptoms of			(F) Verify that there is appropriate			
	delirium, behavior	s affecting others or psychosis.			documentation that supports the target			
	The February 201	O physician's orders were			behavior and use of the medication in t			
		9 physician's orders were nt #11 had orders for Buspirone			clinical record including progress notes electronic medication administration	,,	<b> </b>	
		s) by mouth tid (three times a			record, care plan etc.		<b> </b>	
		'5 mg daily for depression,			100014, ouro piari oto.			
		g by mouth daily at bedtime,			The results of the interviews and review	NS		
		mouth bid (twice a day), and			will be discussed by the Director of	-	<b> </b>	
	Valproic acid 250				Nursing/Designee monthly for three (3)	)	<b> </b>	
		-			months at the Quality Assurance			
	Resident #11's cui	rrent comprehensive care plan			Performance Improvement Committee			
	dated 8/29/18 doc	umented psychotropic drug use			Meeting (QAPI). The interdisciplinary			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	as a problem. Approto my physician any to my physician any to could be associated wadminister my medical physician and implemeducate me and/or mrisks/benefits of psycome for effectiveness of monitor me for changed dose may need reducincreasing, communic pharmacy/interdiscipl recommendations to evaluate me on a perdose reduction or discontinuous to a perdose reduction or discontinuous to the current comprehed address targeted behaviors identified of dated 8/29/18 read, "disrupting behaviors and wheels off."  The psychiatric nursed dated 12/3/18 read in schizoaffective disord Depakote for mood seval (evaluation) for conference of Depakote 250 mg (medication) adjustmost. 5 mg added on 9/3 depression, r/t (related grandson is facing, slistable. Recommendation 50 mg qd and do not seval to so mg qd and t	aches checked were report roublesome symptoms that with use of the drug, ations as prescribed by the nent behavioral interventions, y family on potential hotropic drug use, monitor of psychotropic drug use, es that may suggest my etion, discontinuation, or eate changes and any inary team me and my physician, iodic basis for a gradual continuation, if applicable.  Lensive care plan did not aviors for Buspar, Geodon, and Valproic acid or identify interventions. Two in the activity care plan I will occasionally have during activities-gets angry  Le practitioner progress note part "Patient with ler, on Geodon and tability, pharmacy request yor (gradual dose reduction) bid, patient with med ents for depression, Effexor	F 75	team (IDT) will make recommendat for revisions as indicated necessary sustain substantial compliance.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII				(3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RETREAT		514 NORTH	DRESS, CITY, STATE, ZIP CODE H MAIN STREET ETREAT, VA 24368	1 00	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 758	no targeted behaviors note other than situated 12/27/18 read idepressive symptoms increased Effexor to a today she reports mile been sad past few dadeceased. She contiand finds it helpful, Dostability and trazodom patient has remained current comprehensivany of these concerns.  The psychiatric nursed dated 1/16/19 read in bipolar moods with m 7.5 mg tid has failed increase in anxiety. Find doing ok now, and sle comprehensive care these concerns.  The surveyor informed director of nursing (Doregistered nurse, and nursing of the above p.m. The DON was a know what behaviors DON stated that behaviors DON stated that behaviors and choose from the symptoms.  The surveyor requesting the surveyor requ	sidentified in the progress ional with grandson.  It practitioner progress note in part "Patient with grandson,"  It per her report, last visit KR75 mg qd (every day), dimprovement, but has anys as her cousin recently inces on buspar for anxiety epakote Geodon for mood er for insomnia. Staff report overall at baseline." The recease plan did not identify is.  It practitioner progress note part: "Patient with history of ood instability. On buspar coast attempts of gdr, with relation treports moods are seep is good." The current plan did not identify any of the administrator, the ON), the corporate the assistant director of concern on 2/27/19 at 3:04 asked how does the staff are being targeted. The avior monitoring was not is for the entire shift. Staff is when charting where they full array of psychological	F	758				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING		C 03/05/2019
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		1 00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	"Behavioral Assess Monitoring" on 3/1/ "Management:  2. The care plan wil comprehensive ass with current standar  7. Interventions will an overall care environments trives to understar resident's distress of the standar and detailed assessmand behavioral symbol causes, as well as the environmental reas care plan will included description of the befrequency, intensity environment, and particularly and particular	wed the facility policy titled ment, Intervention, and 19. The policy read in part I incorporate findings from the essment and be consistent rds of care. be individualized and part of fronment that supports and psychosocial needs, and id, prevent or relieve the or loss of abilities. I dapproaches will be based on ent of physical, psychological ptoms and their underlying the potential situational and ons for the behavior. The le, as a minimum: a. a enavioral symptoms including industrial days and their underlying characteristic symptoms including industrial symptoms. I cation, recipitating factors. b. I dualized interventions for the sychosocial symptoms. c. The envention and approaches. d. I intervention. gic approaches will be utilized to avoid or reduce the use dications to manage	F 758	,	
	behavioral sympton rationale for use, po the behavior, other tried prior to the use	ons are prescribed for one, documentation will include otential underlying causes of approaches and interventions of antipsychotic medications, benefits of medications as			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	CONSTRUCTION	COMPLETED
		495417	B. WING		C 03/05/2019
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT  SUMMARY STATEMENT OF REFIGIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		1 03/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 758	discussed with the target behaviors and dosage, duration, in adverse consequer dose reduction.  The DON provided down box (special respecial Requirement and drop down box for following behaviors down box that staff. This was not personal box included throwing smearing bodily was other-see nurses not self, scratching self sexual acts, hitting, grabbing, sexually a screaming, and curt the drop-down box.  No further informative action of the clinical record	resident and/or family, specific d expected outcomes, nonitoring for efficacy and nees, and plans for gradual  a "screenshot" of the drop requirements) used for ation targeted behaviors. The ent Type (View Only)" included r "Behavior Types." The were included in the drop can choose for the behavior. Incentered. The drop downing food, smearing food, stes, disruptive sounds, otes, disruptive sou	F 758		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	ı , ,	TE SURVEY MPLETED
		495417	B. WING			C <b>3/05/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 0	3/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCE OF	JLD BE	(X5) COMPLETION DATE
F 758	depressive disorder pain syndrome, Vita paroxysmal vertigo, chronic obstructive pain syndrome, Vita paroxysmal vertigo, chronic obstructive pain syndrome.  Resident #3's annual assessment with an (ARD) of 2/6/19 ass BIMS (brief interviewevidence of delirium psychosis.  Resident #3's Februa were reviewed. Resident #3's Februa were reviewed. Resident #3's had a was at risk for side and was at ri	mia, hypothyroidism, major insomnia, anxiety, chronic min D deficiency, benign morbid obesity, hypertension, bulmonary disease, type 2 asal congestion, and al minimum data set (MDS) assessment reference date essed the resident with a vifor mental status) as 15. No in behaviors affecting others or ary 2019 physician's orders sident #3 was prescribed iniligrams) daily and it bedtime.  The detection of the current explan dated 2/20/19. It care plan that read resident effects of psychotropic pressants and antianxiety-dx depression, anxiety, and aches: Document resident explands and the cological interventions.  The detection of the current explands are plan that read resident effects of psychotropic pressants and antianxiety-dx depression, anxiety, and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and antianxiety and aches: Document resident explands are plands and aches are plands and antianxiety and aches are plands and aches a	F 75	8		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495417	B. WING		C 03/05/2019	
1	STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368		03/05/2019	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
avior monitoring was not as for the entire shift. Staff at when charting where they full array of psychological atted the facility policy tions and the drop down box and the drop down box and the facility policy titled then, Intervention, and and and the consistent and be consistent as of care. The individualized and part of comment that supports and psychosocial needs, and and psychosocial needs, and and psychosocial needs, and and psychosocial needs, and and psychosocial psychological and the properties and their underlying the potential situational and the potential situational and the properties and psychosocial symptoms including duration, outcomes, location, ecipitating factors. b. Intervention and approaches. d. able goals for targeted the staff will monitor for	F 75	8		
	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 135  THE ART STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 135  THE ART STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 135  THE ART STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 5 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 4 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 5 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF DEFICIENCIES CY MUST BY FULL LSC IDENTIFYING INFORMATION)  THE 6 STATEMENT OF THE 135  THE 6	A95417  RETREAT  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Re 135  Re 135  Re for the entire shift. Staff st when charting where they full array of psychological  Reted the facility policy titled thent, Intervention, and sessment and be consistent do for care. De individualized and part of conment that supports and psychosocial needs, and dr., prevent or relieve the folions and their underlying the potential situational and the staff will be based on the staff will monitor for the staff will monitor for intervention. Ic approaches will be utilized	RETREAT  RETREAT  STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368  D PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCE DO TO THE APPRO DEFICIENCY)  Re 135  Lavior monitoring was not dested the facility policy full array of psychological sted the facility policy titions and the drop down box  and psychosocial needs, and dested the resement and be consistent dested or or relieve the relieve or relieve the relieves of abilities.  Laproaches will be based on and of physical, psychological stoms and their underlying the potential situational and the for the behavior. The dested and approaches will be based on and of physical, psychological stoms and their underlying the potential situational and the form the relieve the dested the potential situations including duration, outcomes, location, decipitating factors. b. ualized interventions for the eychosocial symptoms. c. The revention and approaches. d. able goals for targeted the staff will monitor for intervention.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	' '	ATE SURVEY OMPLETED
		495417	B. WING		,	C 03/05/2019
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT				STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368		30/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	behavioral symptom 10. When medicatic behavioral symptom rationale for use, pot the behavior, other tried prior to the use potential risks and be discussed with their target behaviors and dosage, duration, madverse consequent dose reduction.  The DON provided down box (special repsychotropic medical "Special Requireme a drop down box for following behaviors down box that staff. This was not persor box included throwing smearing bodily was other-see nurses not self, scratching self, sexual acts, hitting, grabbing, sexually a screaming, and curst the drop-down box at the above concerns the above concerns the drop-down box at the drop-down box a	dications to manage	F 75	8		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		495417	B. WING _			C <b>03/05/2019</b>
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT		RETREAT		STREET ADDRESS, CITY, STATE, ZIP COE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		30/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758	exit conference on 3/s  4. The facility staff faitargeted behaviors for #101 was prescribed. The clinical record of reviewed 2/26/19 throwas admitted to the fareadmitted 2/15/19 with but not limited to alter levels of serum enzyr behavioral disturbanch hypothyroidism, seizumuscle weakness, dychronic kidney diseast hypertension, fever, eperipheral autonomic mellitus, Parkinson's frequent micturition, are sident #101's admit (MDS) assessment with a BIMS status) as 11. No assidelirium, behaviors af The surveyor reviewer comprehensive care part of the comp	led to identify specific r Resident #101. Resident Zoloft and Namenda.  Resident #101 was augh 3/5/19. Resident #101 acility 1/31/19 and at diagnosis that included are mental status, abnormal anes, dementia without es, Vitamin deficiency, ares, difficulty in walking, sphagia, encephalopathy, are, stage 2, hyperlipidemia, adema, insomnia, idiopathic neuropathy, type 2 diabetes disease, repeated falls, and hypoglycemia. Assission minimum data set ith an assessment of 2/7/19 assessed the (brief interview for mental aressed signs or symptoms of a fecting others or psychosis.  Ind Resident #101's current plan. The care plan dated arm at risk for side effects and document behaviors. A dropics as ordered." The ad 2/6/19 for withdrawn: that the resident spends does not talk very much,	F 7	58		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368		DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		
F 758	Resident #101 also I that read "I have not to) my diagnosis of A dementia, altered me encephalopathy. Ap concerns about conf with my provider and aware the provider well as pharmacy, st (signs/symptoms) of provider, I ask that the as needed, and I ask dignity, talk to me ar providing care."  Resident #101's Feborders read in part, "(milligrams) take one Memantine 10 mg by The surveyor informedirector of nursing (Experience of the above p.m. The DON was know what behaviors DON stated that behaviors DON stated that behave a drop down list can choose from the symptoms.  The surveyor request psychotropic medical for behaviors.  The surveyor review "Behavioral Assessing the surveyor review" Behavioral Assessing the surveyor review "Behavioral Assessing the surveyor review" "Behavioral Assessin	nad a care plan dated 2/11/19 ed cognitive loss r/t (related alzheimer's disease, ental status, and proaches: I will discuss usion and disease processes I family as needed, I am vill review my medications, as aff will observe for any s/s infection and notify my ne staff provide reorientation at that the staff promote densure my privacy when setablet by mouth daily and y mouth two times a day."	F7	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING		C 03/05/2019
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 758	comprehensive assivith current standar 7. Interventions will an overall care enviphysical, functional strives to understan resident's distress of 8. Interventions and a detailed assessment and behavioral symbol causes, as well as the environmental reast care plan will included description of the befrequency, intensity, environment, and put and the properties of the 9. Non-pharmacology to the extent possibility of antipsychotic medical symptom 10. When medication behavioral symptom 10. When medication behaviors and discussed with the rarget behaviors and dosage, duration, more strictly symptom 10.	incorporate findings from the essment and be consistent ds of care. be individualized and part of ronment that supports and psychosocial needs, and d, prevent or relieve the r loss of abilities. If approaches will be based on ent of physical, psychological potoms and their underlying the potential situational and the potential situational and the potential situational and the potential symptoms including duration, outcomes, location, recipitating factors. b. Itualized interventions for the sychosocial symptoms. c. The rention and approaches. d. rable goals for targeted the staff will monitor for intervention. Gic approaches will be utilized to avoid or reduce the use dications to manage	F 758		

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		03/05/2019
	OVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	03/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	Continued From pag	ue 140	F 758	3	
	down box (special repsychotropic medical repsychological Requirement of the following behaviors of the following behaviors of the following self, scratching self, scratching self, scratching self, sexual acts, hitting, legrabbing, sexually alsocreaming, and curst the drop-down box at the following self, scratching self, scratching self, scratching, and curst street of the following self, scratching and curst street of the following self, scratching self, scratching and curst self self self self self self self self	ing. None of the behaviors in are resident specific.  In was provided prior to the 4/5/19.  I ailed to identify and monitor of Resident # 36 while taking			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		PLETED
		495417	B. WING			C (05/2040
NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368		03/05/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 758	anxiety. The survey documentation of tat #36 in the clinical re At 3:30 pm, the survey of nursing) where th targeted behaviors in DON stated, "On the boxes that has beha specific for each res On 3/5/19 at 4:20 pr administrative team findings.  No further informatic surveyor prior to the 7. For Resident #15 psychotropic medica only administered fo symptoms after non were attempted.  Resident #15 was at 11/22/15 and readmincluded heart failured disease, psychotic of tract infection (UTI), disturbance, dyspha weakness, and diffic quarterly minimum of assessment references ored 3/15 on the bestatus and was assed delirium, psychosis, The assessment ind ambulated and used assistance, was freed	e resident two times a day for or could not find geted behaviors for Resident cord. eyor asked the DON (director e staff was to document in the clinical record. The MAR they have drop down viors listed but they are not ident."  In, the surveyor notified the of the above documented  In was provided to the exit conference on 3/5/19. In, staff failed to ensure that attions Haldol and xanax were in the treatment of specific pharmacologic interventions  Idmitted to the facility on stated on 11/18/18. Diagnoses in the president with behavior gia, anxiety, muscle attack assessment with the date 11/15/18, the resident with grief interview for mental issed as without symptoms of or behaviors affecting care.	F 75			

AND DI AN OF CODDECTION IDENTIFICATION NUMBER.		1 ' '	LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C / <b>05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		03/03/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 758	Clinical record review dated 2/10/19 "take of tow and one 0.5 mg order did not give an administration of xanswere limited to 2/10/2 behaviors noted "7p-administration record resident exhibit behaviors noted "N" (no) for A nurse's note dated documented "late enforders received for H now due to increased 5mg/ml given at 13:3 effective results noted aggitated". Haldol disphysician order list or administration record indicating the resident the medication admir question" Did Reside this shift?" Was answered.	revealed a physician order one 0.5 mg (milligram) xanax canax in two hours". The indication for the eax. Nursing notes on 2/10 to 19 8:38 AM "no negative 7a". On the medication of the question of the question of the question of the property of the proper	F 75	8		
	concerns with psychoreasons for administr documentation during 3/4/19. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensure	g a summary meeting on f Significant Med Errors	F 76	0		4/19/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C 03/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				514 NORTH MAIN STREET	
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
F 760	Continued From pag	e 143	F 76	0	
	This REQUIREMEN by:	Γ is not met as evidenced			
	Based on staff interv	view, clinical record review,		For Resident #36, person centered	
		t review, facility staff failed to		targeted behaviors have been identifi	
		re free of unnecessary		documented and monitored in the clin	nical
		28 residents in the survey		record by the Director of	
	sample (Resident #3	6, 101, 19, 362, 45, and 17).		Nursing/Designee for the use of	_
	The findings included	4.		psychotropic medication that includes	
	The illialitys illiaded	1.		Xanax. The physician and the respor party have been notified of the varian	
	1. The facility staff	failed to ensure Resident		the Director of Nursing/Designee. The	-
	_	ecessary medications.		were no adverse effects to the reside	
		, ,		related to the variance. Resident #36	
	Resident #36 was ac	lmitted to the facility on		longer resides at the facility. Residen	t
	8/5/15 with the follow	ring diagnoses of, but not		#101 no longer resides at the facility.	For
		art failure, high blood		Resident #19, the physician and the	
	pressure, diabetes a			responsible party have been notified	by
	, ,	num Data Set) with an ARD		the Director of Nursing/Designee	
	``	nce Date) of 12/18/18, the		regarding the medication variances for	
		as having a BIMS (Brief		Lantus and Novolog sliding scale inst	
		Status) score of 15 out of a Resident #36 was also		the technical issue with the computer resulting in the inability to document	
	·	xtensive assistance of 2 staff		amount of sliding scale insulin has be	
		g, personal hygiene and		resolved for Resident #19. There wer	
	bathing.	g, percena nyglene and		adverse effects to resident #19 relate	
				the medication variances for Lantus a	
	During the clinical re	cord review on 3/4/19 at 2:04		Novolog insulin. For resident #17, the	•
	pm, the surveyor not	ed a physician order Xanax		physician and the responsible party h	nave
	that was given to the	resident two times a day for		been notified by the Director of	
	anxiety. The surveyo			Nursing/Designee regarding the omit	
		geted behaviors for Resident		accuchecks prior to insulin administra	
		cord to support the continued		for the following dates and times: 7:3	
	use of Xanax.			11:30am and 5:30pm on 2/5/19, 2/11	
	A4 0,00 mm - 41	aven paled the DOM (direct)		2/12/19, 2/14/19 and 2/26/19. There	
		eyor asked the DON (director		no adverse effects to the resident rela	
	~ .	e staff was to document		to the variances for omitted accuched For Resident #45, the physician and	
	_	the clinical record. The MAR they have drop down		responsible party have been notified	
		viors listed but they are not		the Director of Nursing/Designee	-y
	Sonoo ii lat Hao bolla	riolo notoa pat trioy are riot	1	in Director of Harding/Designed	

		L IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	495417 B. WING		02/		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0,	3/05/2019	
TO UNE OF TH	TO VIDEIX OIX OUT I EIEIX			514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT					
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag	ne 144	F 76	0			
	specific for each res	ident."		regarding the insulin variances			
				at 11:30am and 5:30pm; and or			
		n, the surveyor notified the		at 7:30am, 11:30am and 5:30pi			
		of the above documented		were no adverse effects for res	ident #45		
	findings.			related to these variances.			
	No further information	on was provided to the		A review has been conducted b	ov the		
		exit conference on 3/5/19.		Director of Nursing/Designee of	-		
	2. The facility staff fa			following areas:			
	physician-ordered pa			(A) Residents with physician	s orders for		
		ling scale insulin for Resident		psychotropic medications have			
		ocument when insulin was		clinical record review to ensure	that		
	administered.			person-centered specific target	ted		
				behavior have been identified a	and		
	The clinical record of			documented in the clinical reco			
		rough 3/5/19. Resident #362		(B) Residents with physician □			
	was admitted to the			insulin including sliding scale in			
	_	ded but not limited to left		specific parameters have had the			
		injury, cataract, anemia, type urine retention, bipolar		physician □s orders and electro medication administration reco			
		akness, difficulty in walking,		for the previous thirty (30) days			
		pertension, chronic pain,		further variances with following	•		
		: disease, TIA (transient		physician □s orders for parame			
		perlipidemia, intervertebral		administration of sliding scale in			
		lumbosacral region, and		well as omissions in the docum			
	edema.	_		the electronic medication admir	nistration		
				record when insulin was admin	istered.		
	The admission minir			The physician and responsible			
	assessment had not	yet been completed.		been notified of findings and no			
	_ ,, ,			have been documented in the o	clinical		
		rent comprehensive care plan		record by the Director of			
		I have a dx (diagnosis) of		Nursing/Designee. Additionally	, tne		
		lycemia. Approaches:		Administrator/Director of	ad tha		
	MD (medical doctor)	nedications as ordered per		Nursing/Designee have reviewed			
	(ווופעונאו עטטנטו) שואי			documentation regarding amou insulin administered for those re			
	Resident #362's Fah	ruary 2019 physician's		with physicians orders for ins			
		d. Resident #362 had orders		ensure that Licensed Nurses a			
		00 unit/ml (milliliter) vial		document the specific amount			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B WING		C	
NAME OF D	ROVIDER OR SUPPLIER	433417	B: WiiNO	STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2019	
NAME OF PI	ROVIDER OR SUPPLIER						
CARRING	TON PLACE AT RURAL	RETREAT		514 NORTH MAIN STREET			
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag	e 145	F 76	60			
	Inject 5 units subcuta	aneously before		administered.			
		ood sugars less than 140****		(C) The Director of Nursing/Do	esignee		
		t/ml vial inject 60 units		have conducted a review for re			
	subcutaneously twice			with physician □s orders for Ac	cuchecks		
	•	•		and sliding scale insulin for the	previous		
	The surveyor review	ed the February 2019 blood		thirty (3) days to identify furthe	r variances		
	sugars documented	on the electronic insulin		in which the physicians order v	vas not		
	medication administr	ration record (Insulin MAR).		followed to obtain blood glucos	se reading		
				prior to insulin administration to	o ensure		
	The blood sugar doo	cumented for 2/15/19 at 7:30		that insulin is only administered	d when		
		dent #362 was administered		blood sugar readings were with	nin the		
	_	e left upper quadrant. Insulin		administration parameters. Ad	-		
		eld per the physician order to		the review will identify further v			
	hold insulin when blo	ood sugar was less than 140.		with physician □s orders to hole			
				when blood glucose readings r			
		2/17/19 at 7:30 a.m. was 99		parameters. The physician and			
		og was administered in the		responsible party have been n			
		The insulin should have		further variances identified and			
	been held per the ph	iysician order.		documented in the clinical reco Director of Nursing/Designee.	ord by the		
		2/21/19 at 7:30 a.m. was 77					
		og were administered in the		Education has been provided t			
		Insulin should have been		licensed nurses by the Directo			
	held per the physicia	ın order.		Nursing/Designee regarding th areas:	e following		
	The blood sugar on 2	2/21/19 at 5:30 p.m. was 126		(A) The facility must ensure th	nat its		
	and 5 units of Novolo	og was administered in the		residents are free of significant	t		
	left upper arm. Insul	lin should have been held per		medication errors.			
	the physician order.			(B) Licensed nurses are expe	cted to		
				follow the six (6) rights of medi	cation		
		ed the director of nursing of		administration and administer	medications		
	the above issue on 2	2/27/19 at 4:32 p.m.		as ordered by the physician			
				(C) Residents with physician			
		in MAR details for February		psychotropic medications mus			
	2019 found the follow	wing areas of concern:		person centered specific targe			
				behaviors identified and docun			
		or administration on 2/14/19		the use of psychotropic medica			
		documented administered		(D) The licensed nurses must			
	until 10:00 p.m.			physician □s orders for accuch	ecks and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495417	B. WING		0,	C 3/05/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/03/2019	
			514 NORTH MAIN STREET			
CARRINGTON PLACE AT RUF	RAL RETREAT		RURAL RETREAT, VA 24368			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
at 8:00 a.m. was until 11:48 a.m. Novolog insulin s a.m. was not doc 11:48 a.m. Levemir schedule at 8:00 p.m. was administered until Levemir schedule at 8:00 p.m. was administered until Novolog schedule at 7:30 a.m. was administered until Levemir schedule at 8:00 a.m. was administered until Novolog schedule at 11:30 a.m. was administered until Levemir schedule at 8:00 p.m. was administered until Levemir schedule at 8:00 a.m. was administered until Levemir schedule at 8:00 a.m. was administered until Levemir schedule at 7:30 a.m., 11:3 documented adm p.m. Levemir schedule at 8:00 p.m. was administered until Levemir schedule at 8:00 p.m. was administered until Levemir schedule at 9:00 p.m. was administered until Levemir schedule	and for administration on 2/15/19 and documented administered cheduled for 2/15/19 at 7:30 aumented administered until and for administration on 2/15/19 and documented as 1 2/15/19 at 9:43 p.m. and for administration on 2/16/19 and documented as 1 2/17/19 at 1:42 a.m. and for administration for 2/20/19 and documented as 1 2/20/19 at 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m. and for administration on 2/20/19 and documented as 1 10:26 a.m.	F 76	administration of sliding scale insist there are physician ordered parar for the administration of insulin, the licensed nurse must also accurate document the administration of medications including but not limit insulin administration.  (E) The licensed nurse must folke physician sorders to hold insulin blood glucose readings meet the parameters.  The Director of Nursing/Designeet conduct a weekly review for threet residents for three (3) months of the following areas:  (A) Residents with physician sorder and documented in the clinit record  b. The six (6) nights of medication administration has been followed administration of medications including the following scale insulin contained physician sorders and insulin insuling scale insulin either administed based on the physicians order parameter.  d. Omitted medications including accuchecks and insulin must be documented accurately in the clinited of the physician and response must be notified timely at the time omission and documented approprint the clinical record.  The results of the interviews and the contained of the physician record.	neters le lely led to low when hold will (3) he orders for log cian cal on for luding er the cluding stered or lered g ical ible party of oriately		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE	00/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	at 7:30 a.m. was not administered until 8:4 Novolog scheduled for at 11:30 a.m. was not administered until 6:0 Levemir scheduled for at 8:00 p.m. was not administered until 2/2 Novolog scheduled for at 7:30 a.m. was not administered until 9:0 Levemir scheduled for at 8:00 a.m. was not administered until 9:0 Levemir scheduled for at 8:00 p.m. was not administered until 11:1 The surveyor informeteam of the above comeeting on 3/5/19 at stated the facility had replaced them so the The surveyor asked for were provided.  The surveyor request policy for the care of administration policy. Care of the Resident "8. Assist the residen medication regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of administration regimen, The policy titled "Doc Administration" read in the surveyor request policy for the care of the Resident "Doc Administration" read in the surveyor request policy for the care of the Resident "Doc Administration" read in the surveyor request policy for the care of the Resident "Doc Administration" read in the surveyor request policy for the care of the Resident "Doc Administration" read in the surveyor request policy for the care of the Resident "Doc Administration" read in the surveyor request policy for the care of the sur	or administration on 2/25/19 documented as 0 a.m. or administration on 2/25/19 documented as 19 p.m. or administration on 2/25/19 documented as 16/19 at 2:20 a.m. or administration on 2/26/19 documented as 13 a.m. or administration on 2/26/19 documented as 15 a.m. or administration on 2/26/19 documented as 16 a.m. or administration on 2/26/19 documented as 16 a.m. or administration on 2/26/19 documented as 17 a.m. or administration on 2/26/19 documented as 18 a	F 76	will be discussed by the Dire Nursing/Designee monthly for months at the Quality Assura Performance Improvement C Meeting (QAPI). The interdisteam (IDT) will make recomm for revisions as indicated necesustain substantial compliance.	or three (3) ance committee ciplinary nendations cessary to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1	0.750,2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	E ACTION SHOULD BE COMPLET DATE DATE		
F 760	Continued From pag	ge 148	F 70	60			
	No further information exit conference on 3	on was provided prior to the 3/5/19.					
	_	ailed to document when insulin were administered to					
	reviewed 2/26/19 th was admitted to the readmitted 2/15/19 to but not limited to altered soft serum enzybehavioral disturbar hypothyroidism, seizmuscle weakness, ochronic kidney diseathypertension, fever, peripheral autonomic	with diagnosis that included ered mental status, abnormal ymes, dementia without aces, Vitamin deficiency, zures, difficulty in walking, dysphagia, encephalopathy, ase, stage 2, hyperlipidemia, edema, insomnia, idiopathic c neuropathy, type 2 diabetes is disease, repeated falls,					
	(MDS) assessment reference date (ARI resident with a BIMS status) as 11. No as	mission minimum data set with an assessment 0) of 2/7/19 assessed the 6 (brief interview for mental ssessed signs or symptoms of affecting others or psychosis.					
	2/11/19 read "I have	hensive care plan dated a dx (diagnosis) of diabetes. hister routine medications as edical doctor)."					
	orders read in part " vial inject 25 units s day) ***Hold if less t	oruary 2019 physician's Lantus 100 unit/ml (milliliter) ubcutaneously bid (twice a han 140***." Humulin N 100 s subcutaneously every day					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B. WING		C 03/05/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	U3/	05/2019
CARRING	TON PLACE AT RURAL I	RETREAT			14 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	The surveyor reviewer electronic insulin media record (e-Insulin MAF  The following issues of MARs were identified 2/1/19 Lantus schedur documented as admir p.m.  2/2/19 Lantus schedur documented as admir a.m.  2/4/19 Lantus schedur documented as admir 2/1/19 Lantus schedur documented as admir 2/1/1/19 Lantus schedur documented as admir a.m.  2/11/19 Humulin schedur documented as admir a.m.  2/15/19 Lantus schedur as admir a.m.	d the February 2019 lication administration R).  with the February 2019 : led at 9:00 p.m. was not histered until 2/1/19 at 10:37  led for 9:00 p.m. was not histered until 2/3/19 at 2:32  led for 9:00 p.m. was held. Is did not occur until 2/5/19 at 10:37  led for 9:00 p.m. was not histered until 11:07 p.m. Iled at 9:00 p.m. was not histered until 11:55 p.m. Iled at 9:00 p.m. was not histered until 11:14 p.m. Iled at 9:00 p.m. was not histered until 11:11 p.m. Iled at 9:00 p.m. was not histered until 2/12/19 at 4:00  Induled at 9:00 a.m. was not histered until 2/12/19 at 4:53  Illed for administration at cumented as administered a.m. Illed for administration at umented as administered	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B. WING			05/ <b>2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE  14 NORTH MAIN STREET  RURAL RETREAT, VA 24368		50.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	9:00 p.m. was not do until 2/17/19 at 11:41 2/18/19 Humulin sche 7:30 a.m. was not do 11:34 a.m. 2/20/19 Lantus sched documented as admi 12:14 a.m. 2/21/19 Lantus sched 9:00 p.m. was not do 2/22/19 1:10 a.m. 2/22/19 Lantus sched 9:00 p.m. was not do until 2/23/19 at 3:35 a 2/23/19 Lantus sched 9:00 p.m. was not do until 2/23/19 at 10:29 p.m. Second entry for 2/23 was documented as a 10:52 a.m. The entry removed: Other doct 2/25/19 Lantus sched 9:00 p.m. was not do until 2/25/19 at 10:15 2/26/19 Lantus sched 9:00 p.m. was not do until 2/25/19 at 10:15 2/26/19 Lantus sched 9:00 a.m. was not do until 2/26/19 at 11:25 2/26/19 Lantus sched 9:00 p.m. was not do until 2/27/19 at 12:50 The surveyor informeteam of the above comeeting on 3/5/19 at stated the facility had replaced them so the	duled for administration at cumented as administered p.m. eduled for administration at cumented as omitted until duled for 9:00 p.m. was not nistered until 2/21/19 at duled for administration at cumented as given until duled for administration at cumented as administered a.m. duled for administration at cumented administered until 2/3/19 9:00 p.m. Lantus insulin administered on 2/25/19 at a read "Unsigned record umentation not complete." duled for administration at cumented as administered as administered a.m. duled for administration at cumented as administered	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495417	B. WING _			C <b>03/05/2019</b>		
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	'	00,00,2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 760		sted and reviewed the facility	F 7	60				
	administration policy Care of the Resident "8. Assist the resider medication regimen, The policy titled "Doo Administration" read	diabetics and the medication The policy titled "Nursing t with Diabetes Mellitus" read at with his or her special as ordered and as needed." cumentation of Medication in part "3. Documentation aninimum: d. Date and time of						
	exit conference on 3 4. The facility staff fa	niled to document when sliding scale insulin were						
	2/26/19 through 3/5/ admitted to the facilit 1/19/19 with diagnos limited to methicillin	f Resident #19 was reviewed 19. Resident #19 was ty 11/30/18 and readmitted ses that included but not resistant staphylococcus vated white blood count, and						
	assessment with an (ARD) of 1/22/19 ass BIMS (brief interview There were no asses	y minimum data set (MDS) assessment reference date sessed the resident with a of for mental status) as 13/15. ssed signs or symptoms of affecting others or psychosis.						
	12/11/18 identified a risk for complications hyper-or-hypoglycen	nensive care plan dated problem that read, "I am at s associated with nia. Approaches: Discuss as, fears, issues regarding						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING	<del></del>	C 03/05/2019	
	NAME OF PROVIDER OR SUPPLIER  CARRINGTON PLACE AT RURAL RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 760	ordered."  Resident #19's Februare reviewed. Resident #19's Februare reviewed. Resident #19's Februare	Perform accuchecks as  ruary 2019 physician's orders sident #19 had orders that t/ml (milliliter) inject 40 units the daily and Novolog 100 and scale three times a day od sugars as follows:  lood sugar greater than 400.  Wed the February 2019 edication administration or Novolog sliding scale insuling mentation included the accuchecks result and the site tion. The insulin eMAR had to of Novolog sliding scale for the entire month of wolog sliding scale ordered :00 a.m., 12:00 p.m., and  Wed the February 2019 insuling details had no documentation	F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495417	B. WING		03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 760	stated the facility har replaced them so the The surveyor asked were provided.  The surveyor request policy for the care of administration policy. Care of the Residen "8. Assist the reside medication regimen. The policy titled "Do Administration" readmust include, as a madministration."  No further information exit conference on 35. For Resident #17 blood sugar was meto ensure insulin was blood sugar was wit parameters.  Resident #17 was an 4/19/16. Diagnoses gastroesophageal remellitus, anxiety, de chronic pain. On the assessment reference scored 15/15 on the status and was assed delirium, psychosis, Medication orders in 9/19/18 for "Novologo".	t 4:26 p.m. The administrator d trouble with "routers" and ey would communicate better. for specific dates but none  sted and reviewed the facility of diabetics and the medication of the policy titled "Nursing the with Diabetes Mellitus" read and the medication of the medication of Medication of Medication of Medication of Medication of In part "3. Documentation of In part "3. Documentation of In many the medication of Medication of Medication of Medication of In part "3. Documentation of In many the medication of Medication of Medication of Medication of In was provided prior to the 10/5/19.  To facility staff failed to ensure the medication of Medica	F 760			
	15 units subcutaned meals***hold if blood	ously daily before d sugar less than 120***".				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	495417		B. WING _			03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		00/00/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag	je 154	F 7	60			
	nursing notes did no	inistration record (MAR) or t document blood sugars at or 5:30 PM on February 5,					
	to find the missing b that they would be d administration or wit the order "accu chec before meals and at BG<60 or >450). No documented under t	the medication nurse where lood sugars. The nurse said ocumented with the insulin h the nurse's notes or under cks three times every day bedtime (notify MD for blood sugars were hat order at 7:30 AM, 11:30 February 5, 11, 12, 14, and					
		nd director of nursing were concern during a summary					
	hold orders for insuli readings met the hold readings met the hold readings met the hold Resident #45 was reading to have the hold reading to have the hold reading to hold reading the hold reading to hold reading the hold reading to hold reading the hold readin	eadmitted to the facility on ses including heart failure, ses mellitus, dementia, rder, psychotic disorder, and he quarterly minimum data assessment reference date at scored 9/15 on the brief status and was assessed as rium, psychosis, or behaviors					
	"Novolog 100 u/ml ir	w revealed an order for nject 24 units SQ before I sugar less than 140**". The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B. WING			C 05/2019
	OVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE  14 NORTH MAIN STREET  URAL RETREAT, VA 24368		<b>30</b> / <b>2</b> 0 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	record (MAR) indicate insulin on 1/16/19 with and 119 at 5:30 PM. was blank on at 7:30 on February 26. The nursing notes to explain the administrator and made aware of conceadministration during 3/1, and 3/4.  Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the dapplicable.  §483.45(h) Storage of §483.45(h)(1) In acceptable appropriate acceptable appropriate acceptable.  §483.45(h)(1) In acceptable appropriate acceptable appropriate acceptable applicable.  §483.45(h)(1) In acceptable appropriate acceptable appropriate acceptable applicable.  §483.45(h)(1) In acceptable appropriate acceptable applicable.	dication administration and the resident received the blood sugar 134 at 11:30 The February insulin MAR AM, 11:30 AM, and 5:30 PM record did not contain ain the omissions.  In director of nursing were terns with insulin summary meetings on 2/28, and Biologicals (1)(2)  In Drugs and Biologicals as used in the facility must be the with currently accepted as, and include the and cautionary the proper and Biologicals and Biologicals and county attended the proper and permit only authorized		761			4/19/19

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	03/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 761	be readily detected.	ne 156  nimal and a missing dose can  T is not met as evidenced	F 76	1	
	Based on staff inter and facility documer ensure medications medication carts.  The findings include  1(a). The facility storage and labeling in the nursing facility On 2/26/19 at 4:25 ploose pills in the dramedication cart:  o (1) Black capsu o (1) med. round o (1) pink med pill o (4) white oblong o (1) orange caps o 4 white med pill o 1 yellow large p o 1 blue oblong p o 1 small round pr o 1/2 LARGE whit o 1 orange round o 1 small white pil o Besivance Sus opened date of 11/6, 30 days	d:  r staff failed to provide safe in 5 out of 6 medication carts r, om, the surveyor observed wers for the 500 hallway  le pill yellow  pills ule s iil iil iil iil iil iil iil iil iil i		The loose pills identified in the drawer 500 hallway med cart on 2/26/19 at 4. pm, 600 hallway med cart on 2/26/19 4:45 pm, 200 hallway med cart drawer on 2/26/19 at 6:02 pm, 100 hallway med cart drawers on 2/26/19 at 6:00 pm has been removed and discarded by the Director of Nursing/Designee during the survey process. The Besivance sus to eye drops with the opened date 9/21/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	at rs ed ave ne .6% 18 t ne date ctor y t t tor y cts ed ts.
		e surveyor observed the hallway medication cart		were labeled appropriately with the op- date, and no expired medications wer contained in the medication carts for I wings.	e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C <b>03/05/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/05/2019	
				514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT		RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	following in the 300 h drawers:  o Latanoprost sol (1)  1(d). At 6:02 pm, the following in the 200 h drawers:  o 1 teal colored ob o 1 brown round pi o 1 med whilte round o 2 white oblong pi o 1 small round who 1/2 white pill round o 1 small round tar  1(e). At approximately observed the followinhallway medication cao 1 white capsule o 1 yellow and blace o 1 small pink round o 1 orange capsule o 1 med round whith the surveyor notified (DON) and the corpord documented findings. The surveyor notified the above documented pm. The surveyor as	ill ind pill ill ind pill ill ill ill surveyor observed the allway medication cart  0.005% no open date on it surveyor observed the allway medication cart  long capsule ill ind pill ills ite pill ind i pill iv 6:05 pm, the surveyor g in the drawers of 100 art: ick oblong pill id pill ic	F 76	Education has been provided to nurses by the Director of Nursing/Designee regarding the medication cart cleanliness and labeling and dating of medication weekly verification will be completed three (3) months by the Director nursing/Designee to observe the medication carts.  The results of the interviews and will be discussed by the Directo Nursing/Designee monthly for the months at the Quality Assurance Performance Improvement Community (QAPI). The interdiscip team (IDT) will make recomment for revisions as indicated necessustain substantial compliance.	proper ns. A leted for of e d reviews r of nree (3) e mittee linary idations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
		495417	B. WING _		03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 761	stated, "When the menurses' are to docum opened and discard to the pills should be kneedication cart when they see a pill loose is cart than they are to appropriately."  No further information surveyor prior to the Lab Srvcs Physician CFR(s): 483.50(a)(2)  §483.50(a)(2) The fact (i) Provide or obtain I ordered by a physician practitioner or clinical accordance with State practice laws.  (ii) Promptly notify the physician assistant, rourse specialist of lat outside of clinical refewith facility policies a notification of a pract physician's orders. This REQUIREMENT by:  Based on staff interverview, the facility state ordered laboratory te (Resident #3, Resider Resident #15).  The findings included	are opened. The DON redication is opened, the ent the date in which it was the medication after 30 days. The period in the cards and in the anot administering them. If an the drawers of the med dispose of medications  The was provided to the exit conference on 3/5/19.  Order/Notify of Results (i)(ii)  Cility must- aboratory services only when an; physician assistant; nurse I nurse specialist in the law, including scope of the ordering physician, aurse practitioner, or clinical coratory results that fall therence ranges in accordance and procedures for fitioner or per the ordering  This is not met as evidenced fiew and clinical record aff failed to obtain physician sts for 4 of 28 residents and the period in	F 7		or of re is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>(05/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	05/2019	
CARRING	TON PLACE AT RURA	AL RETREAT		514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
	OLIMANA DVA	OTATEMENT OF REFIGIENCIES			CORRECTION	0.5	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 773	2/26/19 through 3/admitted to the fact 1/8/19 with diagnoto respiratory failur hypercapnia, restle heart failure, atrial apnea, hypokalem progressive neurol disease, hyperlipid depressive disorder pain syndrome, Vit paroxysmal vertigother constructive diabetes mellitus, in migraines.  Resident #3's annuassessment with a (ARD) of 2/6/19 as BIMS (brief interviewe vidence of delirium psychosis.  A physician order of "CBC (complete bloomprehensive mistimulating hormor	of Resident #3 was reviewed 5/19. Resident #3 was ility 4/5/17 and readmitted ses that included but not limited e with hypoxia and ess legs syndrome, diastolic fibrillation, obstructive sleep ia, constipation, idiopathic bathy, gastro-esophageal reflux emia, hypothyroidism, major er, insomnia, anxiety, chronic emin D deficiency, benign or, morbid obesity, hypertension, expulmonary disease, type 2 masal congestion, and unal minimum data set (MDS) in assessment reference date sessed the resident with a ew for mental status) as 15. No m, behaviors affecting others or dated 12/18/18 read in part, cood count), CMP etabolic panel), TSH (thyroid ne), A1C (hemoglobin A1C), in D, Magnesium level today	F 7		o licensed g obtaining lits to sponsible party b results have filed within the freview labs and reviews ector of for three (3) rance Committee sciplinary mendations ecessary to		
	the clinical record leading results of the A1C	wed the laboratory section of out was unable to locate the ordered to be done 12/18/18.  dated 1/10/19 read in part,					
	"BMP (basic metal	polic panel) in 1 month." The the laboratory section of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			1	C 05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	,	STREET ADDRESS 514 NORTH MAIN RURAL RETREA		,	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B FREFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 773	of the BMP ordered to The surveyor informe practical nurse #2 on #2 stated she would of No further results we	s unable to locate the results to be done in February 2019.  d the unit manager licensed 3/4/19 at 4:41 p.m. L.P.N. call the laboratory.  re provided by L.P.N. #2.	F 7	73			
	director of nursing, the nursing, the regional MDS registered nurse nurse of the above co p.m.	d the administrator, the e assistant director of executive, the corporate e and the regional registered oncern on 3/5/19 at 4:26 in was provided prior to the 5/19.					
	The clinical record of 2/26/19 through 3/5/1 admitted to the facility 1/4/19 with diagnoses to Huntington's disease, muscle weakness, dy psychosis not due to physical condition, we post-traumatic stress disorientation, anxiety disorder, altered men cycle metabolism, de classified elsewhere disturbances, hepatic	Resident #74 was reviewed  9. Resident #74 was  / 3/1/18 and readmitted  is that included but not limited  ise, neglected elder,  urinary tract infection,  isphagia, unspecified  a substance or known  eakness, hypertension,  disorder, ataxia,  /, unspecified mood  tal status, disorder of urea  mentia in other disease					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _				C <b>05/2019</b>	
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368	1 00	00/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 773	Continued From page		F7	773				
	(ARD) of 1/16/19 ass BIMS (brief interview There was no evidend affecting others, and	essessment reference date essed the resident with a for mental status) as 3/15. ce of delirium, no behaviors no evidence of psychosis.						
	level dx (diagnosis) ri	ted 11/23/18 read "uric acid ght hand swelling."						
	the clinical record but results of the uric acid	d the director of nursing of						
	director of nursing, th nursing, the regional MDS registered nurse	d the administrator, the e assistant director of executive, the corporate e and the regional registered oncern on 3/5/19 at 4:26						
	exit conference on 3/3 3. The facility staff fa	iled to identify and monitor Resident # 36 while taking						
	8/5/15 with the follow limited to anemia, hear pressure, diabetes ar quarterly MDS (Minim (Assessment Referer resident was coded a Interview of Mental Strong possible score of 15. coded as requiring expanding the strong process of the strong							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C 03/05/2019	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	. RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 773	pm, the surveyor no that was given to the anxiety. The survey documentation of tal #36 in the clinical re At 3:30 pm, the surv of nursing) where th targeted behaviors in The DON stated, "C down boxes that has not specific for each On 3/5/19 at 4:20 pr administrative team findings.  No further informatic surveyor prior to the 4. For Resident #15 a urinalysis as order Resident #15 a urinalysis as order Resident #15 was at 11/22/15 and readmincluded heart failure disease, psychotic disturbance, dyspha weakness, and diffic quarterly minimum of assessment references cored 3/15 on the base of the surveyor by the surveyor prior to the 4. For Resident #15 was at 11/22/15 and readmincluded heart failure disease, psychotic disturbance, dyspha weakness, and diffic quarterly minimum of assessment references or 3/15 on the base of the surveyor prior to the surveyor prior to the 4. For Resident #15 was at 11/22/15 and readmincluded heart failure disease, psychotic disturbance, dyspha weakness, and diffic quarterly minimum of assessment references or 3/15 on the base of the surveyor prior to the surveyor prior to the 4. For Resident #15 was at 11/22/15 and readmincluded heart failure disease, psychotic disturbance, dyspha weakness, and diffic quarterly minimum of assessment references or 3/15 on the base of the surveyor prior to the 4.	accord review on 3/4/19 at 2:04 ted a physician order Xanax a resident two times a day for or could not find regeted behaviors for Resident cord. eyor asked the DON (director e staff was to document in the clinical record. On the MAR they have drop is behaviors listed but they are resident."  In, the surveyor notified the of the above documented  on was provided to the exit conference on 3/5/19. In, facility staff failed to obtain ed.  dmitted to the facility on itted on 11/18/18. Diagnoses ite, hypertension, Alzheimer's isorder, pneumonia, urinary dementia with behavior	F 7	73			
	The assessment ind ambulated and used	or behaviors affecting care. icated the resident I the toilet with 1-2 person juently, but not always,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495417	B. WING				C <b>05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		5′	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	During clinical record a telephone order date with culture and sens order dated 2/19/19 ficatheterization to obt. No notes between 2/attempt to obtain the physician it had not b. The administrator and notified of the concert on 3/4/19.  Assistive Devices - E CFR(s): 483.60(g)  §483.60(g) Assistive The facility must provand utensils for reside appropriate assistance can use the assistive meals and snacks. This REQUIREMENT by:  Based on observation record review, the facility staff failed physician ordered addresidents (Resident #The findings included The facility staff failed Resident #11 on 2/26/19 through 3/5/1	review, the surveyor noted ded 2/14/19 for urinalysis ditivity. There was a second for valium prior to a straight dain the sample for urinalysis. It and 2/19 indicated an sample or to notify the een obtained.  If director of nursing were and during a summary meeting devices devices devices devices devices devices when consuming to ensure that the resident devices when consuming the ensure that the		810	For Resident #11, a divided plate was provided.  A review has been completed by the Administrator/Director of Nursing/Designee for current residents ensure that adaptive devices have bee provided for eating.  Education has been provided to the licensed nurses and the interdisciplinar team by the Administrator/Director of Nursing/Designee regarding provision of	n 'Y	4/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	493417	B. WING_	STREET ADDRESS, CITY, STATE, ZI	•	/05/2019	
NAIVIE OF F	ROVIDER OR SUFFLIER			514 NORTH MAIN STREET	IF CODE		
CARRING	TON PLACE AT RURAL	RETREAT					
	T			RURAL RETREAT, VA 24368		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 810	limited to acute respichronic respiratory farmetabolic encephalor muscle weakness, a pain syndrome, type hypertension, anxiety depressive disorder, polyneuropathy, hypreflux disease, adult schizoaffective disordanemia, dysphagia, disease, urinary tracobstructive pulmonar deficiency.  Resident #11's quart assessment with an (ARD) of 2/13/19 ass BIMS (brief interview There were no assess delirium, behaviors a Section G Functiona Resident #11 require person physical suppextremity assessed (Resident #11's curred dated 8/29/18 had the was at nutritional risk care plan did not have	res that included but not irratory failure with hypoxia, ailure with hypercapnia, pathy, difficulty in walking, cute kidney failure, chronic 2 diabetes mellitus, y, hypothyroidism, major bipolar disorder, okalemia, gastro-esophageal failure to thrive, der, urethral stricture, constipation, Parkinson's tinfection, chronic ry disease, and Vitamin  erly minimum data set (MDS) assessment reference date sessed the resident with a reformental status) as 15. assed signs or symptoms of affecting others or psychosis. I Status was reviewed. Ed supervision and one port. No impairment in upper (GO400A).  Int comprehensive care planter problem that the resident care divided plate listed.	F &	adaptive devices to reside review will be completed Administrator/Designee (3) residents for three (3) ensure residents are had devices for eating provided The results of the interviewill be discussed by the Nursing/Designee month months at the Quality As Performance Improvement Meeting (QAPI). The interview (IDT) will make recomplete for revisions as indicated sustain substantial complete.	dents for eating. A I by the weekly for three ) months to ving adaptive ded to them.  ews and reviews Director of hly for three (3) ssurance ent Committee erdisciplinary commendations d necessary to		
	2/26/19. Resident #1 meal at 6:24 p.m. TI	ed the evening meal on  1 was served the evening  ne surveyor compared the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7 50.1.5			С	
		495417	B. WING _		0:	3/05/2019	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 810	fries, cole slaw, fish, a regular plate. The s nursing assistant #2 t C.N.A. #2 stated the plate. "She's supposer ran out."  The surveyor informed director of nursing, the nursing and the region above concern on 3/1.  No further information exit conference on 3/1.	ent #11's meal of French and brownie was served on urveyor asked certified o read the tray ticket. resident didn't get a divided ed to have one. Maybe they  d the administrator, the e assistant director of nal registered nurse of the 1/19 at 5:34 p.m.  n was provided prior to the 5/19.	F 8				
F 842 SS=D	(i) A facility may not resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a coagrees not to use or except to the extent to do so.  §483.70(i) Medical re §483.70(i)(1) In accorprofessional standard	nt-identifiable information. elease information that is of the public. elease information that is of an agent only in elease the information that is of an agent only in elease the information has facility itself is permitted.  cords. edance with accepted les and practices, the facility all records on each resident.  ented; e; and	F 8-	42		4/19/19	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	CODE	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842	§483.70(i)(2) The faciall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health an eglect, or domestic vactivities, judicial and law enforcement purp purposes, research purpurposes,	lity must keep confidential hed in the resident's records, a or storage method of the release is- r their resident permitted by applicable law;  ment, or health care hed by and in compliance health oversight administrative proceedings, loses, organ donation hurposes, or to coroners, lineral directors, and to avertalth or safety as permitted with 45 CFR 164.512.  Itity must safeguard medical lainst loss, destruction, or larecords must be retained required by State law; or lead at the of discharge when he in State law; or lare after a resident reaches law.  Idical record must containation to identify the resident; ident's assessments; we plan of care and services a preadmission screening	F8	342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 2/05/2040	
NAME OF P	ROVIDER OR SUPPLIER	400417		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/05/2019	
NAME OF T	NOVIDER OR OUT FIER			514 NORTH MAIN STREET			
CARRING	TON PLACE AT RURAL	RETREAT					
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	Continued From pag	ne 167	F 84	12			
	professional's progre (vi) Laboratory, radio services reports as r This REQUIREMEN by: Based on staff inter- review, and clinical r failed to ensure a co for 3 of 28 residents and Resident #15). The findings included 1. The facility staff famedication administer Registered Nurse #1 administered when t removed from the pil	e's, and other licensed ess notes; and blogy and other diagnostic equired under §483.50. T is not met as evidenced view, facility document ecord review, the facility staff mplete and accurate record (Resident #3, Resident #19,  d: ailed to document accurately ered to Resident #3. I charted medication he medication was actually ll cup by the resident.		For Resident #3, a late entry/achas been made by the Director Nursing/Designee to reflect the resident serfusal of the Lasix at 11:17 am. The physician and responsible party have been not regarding the resident serfusal medication and notification has documented in the medical reconstruction and responsible party have been not the Director of Nursing/Designer regarding the variance related to omitted weights for the week of	on 2/27/19 Intified all of the been bord. For all of the betified by the control of the betified by the control of the following		
	2/26/19 through 3/5/ admitted to the facilitation 1/8/19 with diagnose to respiratory failure hypercapnia, restles heart failure, atrial fiapnea, hypokalemia progressive neuropadisease, hyperlipided depressive disorder, pain syndrome, Vital paroxysmal vertigo, chronic obstructive production of the parameter of	s legs syndrome, diastolic brillation, obstructive sleep, constipation, idiopathic thy, gastro-esophageal reflux mia, hypothyroidism, major insomnia, anxiety, chronic min D deficiency, benign morbid obesity, hypertension, bulmonary disease, type 2		through 2/16/19. For Resident aperson-centered specific targets behaviors have been identified documented in the clinical recorphysician was notified by the Di Nursing/Designee regarding syrrequiring treatment with psychomedication orders were entered clinical record for psychotropic medications to specify indication utilization of the Xanax ordered A review has been conducted be Director of Nursing/Designee for following areas:  (A) Review of the electronic meadministration record for reside of medication for the previous the	ed and rd. The irector of mptoms otropic d into the n for . by the or the edication nt refusals		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495417	B. WING_			03/	05/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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	Continued From page assessment with an a (ARD) of 2/6/19 asses BIMS (brief interview evidence of delirium, psychosis.  The surveyor intervier at 11:17a.m. During nurse #1 came in Readminister the morning stated she didn't warroging to get up and gwas given the pill cup. The surveyor reviewer 2019 physician's order Lasix 40 mg (millimouth twice a day.  The surveyor reviewer medication administr 9:00 a.m. box for Lasix with the initials of R.N. medication was admirefused the medication by the surveyor.  The surveyor informed the above concern of DON stated if medication due to refusal, she with the medical of the medical of the medical of the medical of the surveyor.	e 168 assessment reference date assed the resident with a for mental status) as 15. No behaviors affecting others or award Resident #3 on 2/27/19 the interview, registered sident #3's room to any medications. Resident #3 at the diuretic as she was to activities. Resident #3 or and removed the diuretic.  The definition of the diuretic as the was gram and removed the diuretic.  The definition of the diuretic as the was gram and removed the diuretic.  The divident #3's February and are sident #3 had orders gram and the take one by  The dition record. The 2/27/19 six had been documented by the divident #3 on on 2/27/19 as witnessed and the director of nursing of an 3/1/19 at 3:50 p.m. The ations were not administered ould expect the nurses to	TAG	342	days has been completed additional review to ensure that the physician and responsible party have been notified regarding refusals and the notification been documented in the medical record (B) Review of physician sorders for physician ordered weights will be completed by the Director of Nursing/Designee for the previous thirt (30) days to ensure that weights have been obtained as ordered by the physician.  (C) Residents with physician sorders psychotropic medications have been reviewed by the Director of Nursing/Designee to ensure that person-centered specific targeted behaviors have been identified and documented in the clinical record. Additionally, the physician has been notified by the Director of Nursing/Designee regarding resident with behavioral symptoms requiring treatment with psychotropic medication Residents with physicians order for psychotropic medications will be review by the Director of Nursing/Designee to ensure that the physicians order includindication for utilization of psychotropic medications.  Education was provided to licensed	nas d. y s for ses. ved	DATE	
	of practice was to characteristics. The surveyor interviews 3:52 p.m. about the r	The DON stated the standard art and document refusal.  Ewed R.N. #1 on 3/1/19 at medication Lasix inistered when the resident			nursing staff regarding documentation a notification to physician and responsibl party for resident s refusal of medications; indication and implementation of person-centered targeted behaviors prior to utilization of	e		
		ication. R.N. #1 stated, "Did			psychotropic medications. A review will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 842	standards of practadministration from 3/1/19 at 4:03 p.m.  The surveyor revies tandard of practic on 3/1/19. The position of management of the surveyor information of the	design and fix it."  dested the facility policy on side for medication in the director of nursing on a sewed the facility policy and see for medication administration oblicy titled "Documentation of istration" read in part, "3. sust include, as a minimum: e. medication was withheld, not refused."  The assistant director of orporate registered nurse of the 3/1/19 at 5:34 p.m. and again p.m.  Stion was provided prior to the in 3/5/19.	F 84	conducted by the Director of Nursing/Designee on three weekly for three (3) months documentation and notificat of medications, completion ordered weights, and indica implementation of person-citargeted behaviors prior to to five psychotropic medications.  The results of the interviews will be discussed by the Director Nursing/Designee monthly through at the Quality Assur Performance Improvement Meeting (QAPI). The interditeam (IDT) will make recomfor revisions as indicated ne sustain substantial compliant	(3) residents to ensure tion of refusal of physician ation and entered the utilization s. s and reviews ector of for three (3) rance Committee sciplinary amendations ecessary to		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 842	Continued From pag	e 170	F8	42			
		sed signs or symptoms of ffecting others or psychosis.					
	dated 1/15/19 identife Approaches: Weigh	nt comprehensive care plan ied the problem of nutrition. and monitor results on weekly x 4 then monthly if					
	1/18/19 read, "1. Add (twice a day) x 30 da with low Alb (albumin	nunication form dated d Prostat 30 m (milliliters) bid ys given skin breakdown n) level (2-8) and poor po (by onitor weekly weights." 'Agree with above."					
	computer. Weekly w were not found. The	ed the weights entered in the reights beginning 1/18/19 staff have documented (5/19, 2/6/19 and 2/22/19.					
	(DON) of the above i weights on 3/4/19 at	orded on paper for 1/26/19,					
	read "Resident out fo	te dated 1/30/19 at 7:37 p.m. or appointment at wound refused to d."					
	The departmental no read "Resident refus	te dated 2/1/19 at 4:31 p.m. es to be weighed."					
	the week of 2/10/19 thas written the weigh	nable to locate a weight for through 2/16/19. The DON not was recorded in a note but able to locate a note with a					

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F 842	Continued From pag	ge 171	F 8	42		
	documented weight	during the time.				
	provided on paper w	the DON if the weights vere part of the clinical record. would expect staff to the computer.				
	director of nursing, the nursing, the regional registered nurse and	ed the administrator, the he assistant director of l executive, the regional of the corporate MDS RN of the end of the day meeting m.				
	exit conference on 3 3. For Resident #15 document behaviors which required treatr communication with symptoms requiring	i, facility staff failed to exhibited by the resident ment, and to document the physician concerning treatment with psychotropic enter orders for psychotropic				
	dated 2/10/19 "take tow and one 0.5 mg order did not give an administration of xar were limited to 2/10/behaviors noted "7p administration record resident exhibit behaviors answered "N" (no) for A nurse's note dated documented "late en	nax. Nursing notes on 2/10 2019 8:38 AM "no negative -7a". On the medication d, the question" Did Resident aviors this shift?" Was or both shifts on 2/10/19.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	20//255 05 0//25//55	495417	B. WING _		03/05/2019	
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F 842	effective results noted aggitated". Haldol did physician order list or administration record indicating the residen the medication admin question" Did Resider this shift?" Was answon 2/14/19.  The administrative teat concerns with psychologous concerns with psychologous for administrative documentation during 3/4/19.  QAPI/QAA Improvem CFR(s): 483.75(g)(2)(2)(2)(2)(3)(4)(2)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	of without complication, no did RSD only became more did not appear on the on the medication. There were no notes to exhibited behaviors. On istration record, the intresident exhibit behaviors ered "N" (no) for both shifts arm was notified of the stropic medications, their eation, and lack of a summary meeting on ent Activities (iii) assessment and assurance.  Cality assessment and must:  Carent appropriate plans of diffied quality deficiencies;  Carent is not met as evidenced and, staff interview, clinical collity document review, and applaint investigation, facility quality assurance programs	F8	42	4/19/19	
	director was listed as 2/21/19	present but didn't sign in),		identified, and a PIP was developed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 867	PIP (plan in place) Current PIPs- falls/int Weight loss Infection control- impi include cultures were intervention in place; concentrated on track address nursing prace Dining compliance- in correct menu, and tel administrator gets da Decreasing bed alarm and actual results der Hot beverage safety- interventions New this week= medi administration and na Had started narcotic in concentrated on differ in the book, etc. It ha issues such as the co- counts were an issue	ducation for new QAPI, and serventions  Ilemented tracking log to all received and appropriate the infection control plan king and treating, but did not tices during care. Infection control, getting inperature control-lily test tray insections and decrease by 25% creased 33% post injury- extensive idiation administration arcotic reconciliation in the fall, but it rent issues- counting pages and not addressed other bunt. We knew that the in the fall, but had not was ongoing. The policy d.	F 86	On 04/27/19 QAPI meeting was he attendance by The Medical Director Regional Nurse Consultant, and R Director of Operations. Discussion included: Policy Change on Narcotic Recondition (A)Two licensed nurses (typically, nurse arriving on duty and the nurse departing from duty) are required to conduct a reconciliation (i.e. Chand Shift Count) of controlled substance accordance with facility policy and sign a signature log attention and accuracy of the completion and accuracy of the comparison of the actual amount available medication versus the amount of medication available as listed on the perpetual inventory count sheet(i.e. controlled substance count sheet) nurses should visualize both the controlled substance count comparing the nof medication count comparing the nof medication packages (i.e. cards bottles, etc.)  versus the number of controlled substances count sheets; the number of medications packages and the number of controlled substances count sheets should be equal.  (C) It is recommended that this Chang Shift Reconciliation process be applied controlled substances (Schedule I through Schedule 5) and that both	or, legional of ciliation the sector ge of lesting to l		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 867 C	ontinued From pa	ge 174	F 867	performing the reconciliation visualize both the medications being counted a the count sheet.  (D)If inaccuracies are noted, the DON designee should be notified immediate Nurses involved with noting the discrepancy are not permitted to leave facility until debriefed by the DON or designee.  03/01/19 QAPI meeting held to discust 2567/ Plan of correction, review audits and monitoring review compliance. Regional Director of Operation in attendance.  On 03/21/19, The Regional Nurse Consultant educated the QAPI committee on the facility QAPI policy / process used to monitor, sustain facility operational performance through self-identification and improvement in areas where opportunities for improvement have be identified. Monthly QAPI Compliance by the Regional NurseConsultant/Regional Director of Operation to validate compliance with monthly meetings being held and progress on ongoing performance improvement areas that were self-identified. Review of compliance improvement areas that were self-identified. Review of compliance in any need to re-evaluate and revise the action plans will be documented mont 3, then Quarterly. Audits will be kept in Administrator office.	or ely.  e the  ss s for ehly x n the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 867	Continued From page	: 175	F &	Nursing/Designee monthly for three (3 months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendation for revisions as indicated necessary to sustain substantial compliance.	s	
F 880 SS=F	development and trandiseases and infection §483.80(a) Infection program.  The facility must estal and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigatin and communicable distaff, volunteers, visite providing services unarrangement based u conducted according accepted national sta	ntrol blish and maintain an and control program safe, sanitary and eent and to help prevent the asmission of communicable as.  brevention and control  blish an infection prevention IPCP) that must include, at ring elements:  am for preventing, identifying, g, and controlling infections seases for all residents, breventions and other individuals der a contractual pon the facility assessment to §483.70(e) and following	F	380		4/19/19
	but are not limited to:	lance designed to identify				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BI		PLE CONSTRUCTION  G	COMF	(X3) DATE SURVEY COMPLETED	
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F 880	Continued From pag	e 176	F 8	80			
	infections before the persons in the facility (ii) When and to who communicable diseareported; (iii) Standard and trato be followed to pre (iv) When and how is resident; including but (A) The type and dur depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected scontact with resident contact will transmit (vi) The hand hygiene by staff involved in disease of the forrective actions tall \$483.80(a)(4) A systidentified under the forrective actions tall \$483.80(f) Annual resident contact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact with resident contact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact with resident contact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will transmit (vi) The hand hygiene by staff involved in disease or infected scontact will have a staff involved in disease o	y can spread to other  /; m possible incidents of se or infections should be  nsmission-based precautions vent spread of infections; olation should be used for a ut not limited to: ration of the isolation, infectious agent or organism  at the isolation should be the ible for the resident under the es under which the facility rees with a communicable kin lesions from direct s or their food, if direct the disease; and e procedures to be followed irect resident contact.  em for recording incidents acility's IPCP and the sen by the facility.  dle, store, process, and s to prevent the spread of		Certified nursing assistant was on proper Foley care and infection			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X	(X3) DATE SURVEY COMPLETED	
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F 880	Continued From pag	e 177	F 8	80			
	control program and control guidelines for survey sample (Resi	provide an effective infection failed to follow infection 5 of 28 residents in the dent #74, Resident #45, ent #17, and Resident #34).		practices on 03/01/2019. If was placed on contact prepersonal protective equipreprovided to staff. Physicia responsible party were nofailure to initiate antibiotic Resident #45 in a timely n	ecautions and ment was n and tified of the therapy for		
	for preventing, identificand controlling infect diseases for all residuisitors, and other incunder a contractual afacility assessment of \$483.70(e) and follow standards. The line from 2018 and 2019	ailed to implement a system fying, reporting, investigating, ions and communicable ents, staff, volunteers, dividuals providing services arrangement based upon the onducted according to ving accepted national isting of resident infections was incomplete.		Education was provided to regarding infection control hand hygiene on 03/02/19 Assistant Director of Nursi educated by Director of Nuregarding infection control on 03/02/2019. An audit/reconducted for all residents antibiotic therapy to ensur treatment and implementa precautions if necessary.	practices and and 03/03/19. Ing was ursing/Designed and line listing eview was a receiving e initiation of		
	the infection preventi listing for resident inf A review of the 2018 infections did not ide culture results, treatn	3:53 p.m. The ADON (also onist) was asked for the line ections for 2018 and 2019.  line listing for resident ntify date of cultures if done, nent that included type of es and adverse events.		Director of Nursing/Design comprehensive infection of to licensed nursing staff at interdisciplinary team to in of infections, physician no initiation of treatment, doc implementation of isolation necessary. A review will be the Director of Nursing/Design comprehensive infection of solation necessary.	control education and the aclude tracking tification, umentation and an if deemed e completed by		
	the antibiotic ordered the antibiotic, identific if done, total days of	on log for 2019, the name of l, start date and end date of ed pathogen, date of culture antibiotic therapy, outcome were not captured on the log.		for three (3) residents wee months to initiation of trea implementation of contact necessary.  The results of the interview	ekly for three (3) tment and precautions if		
	with infections currer stated, "The bare min	a map where the residents htly were located. The ADON nimum for documentation ew corporate registered		will be discussed by the D Nursing/Designee monthly months at the Quality Assi Performance Improvement	y for three (3) urance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 880	and have started usin criteria staring in Janu provided the surveyor McGeer's criteria curr.  The surveyor reviewer infection control for an included to document antibiotic surveillance a. Resident name and b. Unit and room numer. Date symptoms aped. Name of antibiotic e. Start date of antibiotic e. Start date of antibiotic f. Pathogen identified g. Site of infection h. Date of culture i. Stop date j. Total days of therape k. Outcome; l. Adverse effects  The surveyor informed director of nursing, the regional executive, the nurse of the above conday meeting on 3/5/19.  No further information exit conference on 3/5.  2. The facility staff fa sanitize after removing room of Resident #74.	n the monthly clinical call ag the McGeer's surveillance uary 2019." The ADON r with copies of the rently in use.  In the facility policy on Intibiotic use. The policy It on the facility-approved It tracking form the following: It medical record number Inber Inpeared  In the administrator, the It is assistant director of It registered nurse, the It is corporate MDS registered In the part 4:26 p.m. In was provided prior to the It is assistant director of It is assistant dire	F	880	Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		
	2/26/19 through 3/5/1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CO		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT	•	514 N	ET ADDRESS, CITY, STATE, ZIP CODE IORTH MAIN STREET AL RETREAT, VA 24368	1 00.	30/2010
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F 880	1/4/19 with diagnose to Huntington's disease Parkinson's disease muscle weakness, depsychosis not due to physical condition, we post-traumatic stress disorientation, anxied disorder, altered me cycle metabolism, declassified elsewhere disturbances, hepation Resident #74's 14-declassessment with an (ARD) of 1/16/19 as BIMS (brief interview There was no evider affecting others, and the surveyor observed 2/27/19 at 8:25 a.m. completed the skin as by certified nursing and donned gloves. Upon assessment observed gloves and exited the station, C.N.A. #1 stresident in the wheer room. C.N.A. #1 left room. The surveyor purell in the uniform "No. There's purell was never observed."	ty 3/1/18 and readmitted be that included but not limited ase, neglected elder, urinary tract infection, ysphagia, unspecified a substance or known reakness, hypertension, si disorder, ataxia, ty, unspecified mood intal status, disorder of urea ementia in other disease without behavioral confailure, and acute cystitis.  The analysis of the resident with a resident and was assisted for completion of the skin ation, C.N.A. #1 removed the resident's room. As C.N.A. hall towards the nursing ropped and started to push a lichair towards the dining asked C.N.A. #1 if she had pocket. C.N.A. #1 if she had pocket. C.N.A. #1 to wash her hands or use exiting Resident #74's room	F	380			

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED		
		495417	B. WING			C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	1 03/03/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	The surveyor informed director of nursing, the nursing and the region above concern with the 5:34 p.m. and request handwashing. The Eshould be washed af DON stated wash has the surveyor reviewed "Infection Control Gu Procedures" on 3/5/1 "General Guidelines their hands for ten (1 using antimicrobial owater under the followater under the follow	ed the administrator, the se assistant director of smal registered nurse of the standwashing on 3/1/19 at sted the facility policy on steed the facility policy on steed the facility policy on steed the facility policy. The steed the facility policy titled sidelines for All Nursing 9. The policy read in part 3. Employees must wash 0) to fifteen (15) seconds or non-antimicrobial soap and wing conditions: d. After a was provided prior to the 5/19. Siled to follow infection regards to Resident #34's admitted to the facility on wing diagnoses of, but not surogenic bladder, urinary stia, Multiple Sclerosis and quarterly MDS (Minimum D (Assessment Reference the resident was coded as a Interview for Mental Status) assible score of 15. Resident as requiring extensive members for dressing, at being totally dependent on	F 88(			

	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495417	B. WING		03/05/2019	
	ROVIDER OR SUPPLIER	L RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		1 33/33/23 13	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 880	asked the CNA (cer she could lift the Fo surveyor would see was in the resident. catheter, closest to resident, with bare his size of the Foley car 18 French with a 10 catheter tubing was resident's leg and night The regional MDS (coordinator was with observation. The MCNA that the leg str room. The surveyonurse if the CNA shit touching the Foley on urse stated, "Yes, catheter tubing with surveyor notified the above documented finding conference room.  No further information surveyor prior to the 4. For Resident #15 operationalize contaprotect the resident exposure to infection.  Resident #15 was a 11/22/15 and readmincluded heart failur disease, psychotic of tract infection (UTI),	hower room. The surveyor tified nursing assistant) #1 if ley catheter tubing up so the what size the foley catheter CNA #1 picked up foley where it was inserted into the nands and no gloves on. The theter was observed to be an acc balloon. The Foley also hanging freely by the ot secured with a leg strap. Minimum Data Set) in surveyor during this entire IDS regional nurse told the aps were in Central Supply asked the regional MDS ould have used gloves before batheter. The regional MDS you never touch a Foley your bare hands."The enadministrative team of the se exit conference on 3/2/19. 5, facility staff failed to act isolation in a manner to and other residents from	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRU A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER TON PLACE AT RURAI	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 880	assessment referen	data set assessment with ce date 11/15/18, the resident	F 880		
	status and was assedelirium, psychosis, The assessment incommodamental and used assistance, was free	orief interview for mental essed as without symptoms of or behaviors affecting care. licated the resident of the toilet with 1-2 person quently, but not always, a prompted toileting program.			
	a telephone order diwith culture and sen order dated 2/19/19 catheterization to obtain the physician it had not an order was writter three times per day infection. On 2/25/19 continue Macrobid a precautions for UTI/ with extended spect	d review, the surveyor noted ated 2/14/19 for urinalysis sitivity. There was a second for valium prior to a straight otain the sample for urinalysis. 1/14 and 2/19 indicated an example or to notify the been obtained. On 2/20/19, in for Macrobid 100 milligrams for 10 days for urinary tract 9. am order was written to and to start contact ESBL (urinary tract infection rum beta lactimase). An exautions was written on			
	when the surveyors 2/26/19. The survey working on 2/28 if the resident had an tract infection and w contact precautions aware of the order. the room door and r the room or outside nursing did not expr	ot on contact precautions entered the facility on yor asked nurses and CNAs ey had been informed that antibiotic resistant urinary ras supposed to be placed on and none reported being No sign had been placed on not PPE had been placed in the room. The director of ess awareness that the on contact precautions during			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		
F 880	was admitted to the h 2/28/19. The record note to indicate the re	ed in F584. The resident	F8	80			
	Resident #17 was ad 4/19/16. Diagnoses i gastroesophageal ref mellitus, anxiety, dep chronic pain. On the assessment reference scored 15/15 on the b status and was asses	a resident with an active ntact precautions.  mitted to the facility on ncluded hypertension, lux disease, diabetes					
	cart outside the resident asked the nurse why precautions. The nur mate was on contact room was on isolation answered call light ar gown, glove, or hand retrieved the room mathen washed hands a 02/28/19 09:00AM the what kind of precaution visiting the resident. ESBL in urine, so "do The surveyor asked waid to wear gloves. contact precautions up to the surveyor asked was a side to wear gloves.	reyor observed an isolation ent's room. The surveyor the resident was on contact se said the resident's room isolation for urine, so the n. 02/27/19 08:39 AM CNA and turned it off without using sanitizer. The CNA then ente's breakfast tray. The aid pproximately 9 seconds. The surveyor asked the nurse ons were necessary when She said that a resident had in't go playing in the pee". What that meant and she The surveyor asked if sually meant to wear gowns id, but she had used the last					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495417	B. WING _				C / <b>05/2019</b>
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL			514 N	ET ADDRESS, CITY, STATE, ZIP CODE  IORTH MAIN STREET  AL RETREAT, VA 24368	1 03	03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	one. The surveyor a gown that was in the when CNAs were in a PPE. She said she to in the cart at least on called for a staff menthere were none in the 10 pack and a secongowns and placed the The surveyor donner interviewed the resid staff rarely wore gow room, although most when cleaning her or said she was unawarshe was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be was supposed to isolation. She said sto wash her hands must be washed to was	sked if it was the same one cart all morning yesterday and out without wearing hought they had put gowns ce the day before. She aber to bring gowns because the cart. The CNA brought a dipackage containing 4 tem in the cart.  If gown and gloves and tent. The resident said that in and gloves when in the staff would wear gloves helping her clean up. She te of any special precautions of take while her room was on the had not been instructed ore often.  If you had a to open, then the surveyor removed to leave the room without in with bare hands.  If director of nursing were in swith contact precautions with contact precautions.	F	380			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE COMP	SURVEY LETED
		495417	B. WING _			03/	05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 880	hypertension, diabete anxiety, bipolar disord schizophrenia. On the set assessment with 12/24/18 the resident interview for mental swithout signs of deliri affecting care.  On 02/26/19, the suncart outside the resid asked the nurse why precautions. The nurcontact isolation for u isolation. On 02/27/19 answered a call light using gown, glove, or then retrieved the then washed hands a The surveyor observe the room without don morning. On 02/28/1 asked the nurse whan necessary when visit that a resident had Explaying in the pee". The meant and she said to surveyor asked if commeant to wear gowns she had used the last they had put gowns in day before. She called bring gowns because The CNA brought a 1 package containing 4 the cart. 28/19 at 9:3 the resident in the room.	es including heart failure, es mellitus, dementia, der, psychotic disorder, and e quarterly minimum data assessment reference date scored 9/15 on the brief tatus and was assessed as um, psychosis, or behaviors veyor observed an isolation ent's room. The surveyor the resident was on contact rese said the resident was on rine, so the room was on at 08:39 AM, a CNA and turned it off without hand sanitizer. The CNA breakfast tray. The aid approximately 9 seconds. Ed staff entering and leaving ning PPE through the 9 at 09:00AM the surveyor thind of precautions were ing the resident. She said SBL in urine, so "don't go The surveyor asked what that to wear gloves. The tact precautions usually and she said that it did, but to one. She said she thought in the cart at least once the ed for a staff member to there were none in the cart.	F 8	80			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495417	B. WING				05/2019
	ROVIDER OR SUPPLIER	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 314 NORTH MAIN STREET RURAL RETREAT, VA 24368		0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	fell closed again while PPE. It was difficult to opening the trash car. A nurse's note dated entry for 1330 (1:30 Fresults. Orders taken to continue macrobid order for "1- Macrobid BID(twice per day) X precautions" was writ 2/25/19 at 8 PM. This than 30 hours after the was given by the nurse. A nurse's note entered documented "residen refusing medications Multiple attempts mad Shifts. The insulin M. documented for 9PM insulin administration medications were downward 100 mg, Lad drops, atorvastatin 10 travatan Z 0.004% eymedications: depakot eye drops, Zyprexa 5 melatonin 3 mg. It was medications were refundinistered. The nuwhether the Macrobid night.	quired 2 hands to open, then a the surveyor removed to leave the room without in with bare hands.  2/24/19 at 7:36 PM as a late PM) "NP notified of ua C&S in for contact precautions and as ordered". A telephone of 100 mg(milligram) in days 2- contact ten by a different nurse on sorder was written more in enote indicated the order see practitioner (NP).  d 2/26/19 at 4:32 AM is in a bad mood and is blood sugar checks. In dec". The nurses work 7-7 AR had N (for see note) and 10 PM accuchecks and on 2/25/19. The 9 PM oral cumented as administered: transprost 0.005% eye in mg, carvedilol 3.125 mg, are drops; and 10 PM as unclear which used and which were rese was unable to confirm it had been administered that in different or mursing were no with contact precautions	F	8880			
	and urinary tract infections of summary meetings of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2013
				514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL	RETREAT	RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 881 SS=F	Antibiotic Stewardshi CFR(s): 483.80(a)(3)	· · ·	F 8	81		4/19/19
	program. The facility must esta	brevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	that includes antibioti system to monitor an	ibiotic stewardship program c use protocols and a tibiotic use. is not met as evidenced				
	Based on staff interv			Resident #64 physician was r 3/6/19 that after the final urine indicated the prescribed antibi resistant to the organism, the received the antibiotic for three days after the final culture residues after of Nursing.	culture otic was resident e (3) more	
	for antibiotic use and use and failed to notinantibiotic ordered for after the final urine coprescribed antibiotic organism. Resident #3 more days after the sent to the facility.	was resistant to the 64 received the antibiotic for final culture results were		The December 2018 and January Antibiotic line listings were upon 3/10/19 to include the date the was started, the length of time antibiotic was prescribed, the conset of symptoms, the type of obtained, the results of the cultany interventions performed, but Director of Nursing.	dated on e antibiotic the date of the f culture ture and	
	nursing on 3/5/19 at 2 the infection preventi- listing for resident infe A review of the 2018 infections did not ider culture results, treatm	wed the assistant director of 2:54 p.m. The ADON (also onist) was asked for the line ections for 2018 and 2019.  line listing for resident ntify date of cultures if done, nent that included type of es and adverse events.		On 03/20/19, the Regional Dir Clinical operations provided training to Director of Nursing, Unit Mana Administrator on Infection Cor Surveillance, Antibiotic stewar has a written antibiotic use pro antibiotic prescribing, including	o the agers and atrol, dship that otocols on	

F 881 Continued From page 188  On the current infection log for 2019, the name of the antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  Tag CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 881  F 881  The ADON did have a map where the residents with infections currently were located. The ADON  Tag CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  The documentation of the indication, dosage, and duration of use of antibiotics; The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		PLETED
CARRINGTON PLACE AT RURAL RETREAT  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 881  Continued From page 188  Continued From page 188  On the current infection log for 2019, the name of the antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  The ADON did have a map where the residents with infections currently were located. The ADON  TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  514 NORTH MAIN STREET  RURAL RETREAT, VA 24368   PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  The documentation of the indication, dosage, and duration of use of antibiotics; The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4			495417	B. WING _			1	
CARRINGTON PLACE AT RURAL RETREAT  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 881  Continued From page 188  Continued From page 188  F 881  The antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  The ADON did have a map where the residents with infections currently were located. The ADON  RURAL RETREAT, VA 24368  RURAL RETREAT, VA 24368  RURAL RETREAT, VA 24368  PROVIDER'S PLAN OF CORRECTION (25)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 881  The documentation of the indication, dosage, and duration of use of antibiotics; The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4	NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
RURAL RETREAT, VA 24368  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 881  Continued From page 188  F 881  The antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  The ADON did have a map where the residents with infections currently were located. The ADON  The ADON did have a map where the residents with infections currently were located. The ADON  TD PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE					51	14 NORTH MAIN STREET		
F 881 Continued From page 188  Continued From page 188  Continued From page 188  Continued From page 188  F 881 Continued From page 188  F 881 Continued From page 188  The antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  The ADON did have a map where the residents with infections currently were located. The ADON  The ADON did have a map where the residents with infections currently were located. The ADON  TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  The documentation of the indication, dosage, and duration of use of antibiotics; The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4	CARRING	TON PLACE AT RURAL	RETREAT		R	URAL RETREAT, VA 24368		
the documentation of the indication, dosage, and duration of use of antibiotics; the antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.  The ADON did have a map where the residents with infections currently were located. The ADON  the documentation of the indication, dosage, and duration of use of antibiotics;  The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
stated, "The bare minimum for documentation was done. With the new corporate registered nurse, I am involved in the monthly clinical call and have started using the McGeer's surveillance criteria staring in January 2019." The ADON provided the surveyor with copies of the McGeer's criteria currently in use.  The surveyor reviewed the facility policy on infection control for antibiotic use titled "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes." The policy read in part, "Antibiotic usage and outcome data will be collected and documented using a facility approved surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.  2. The IP (infection preventionist) or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify situations that are not consistent with the appropriate use of antibiotics.  a. Therapy may require further review and possible changes if:  (1) The organism is not susceptible to antibiotic chosen  (2) The organism is susceptible to narrower spectrum antibiotic.	F 881	On the current infection the antibiotic ordered the antibiotic, identification if done, total days of and adverse events with infections current stated, "The bare min was done. With the nurse, I am involved and have started using criteria staring in Jan provided the surveyor McGeer's criteria current Stewardship-Review Antibiotic Use and Orgart, "Antibiotic usage collected and docume approved surveillance will be used to guide of individual resident practices and facility-  2. The IP (infection preview antibiotic utilizes the stewardship programmare not consistent with antibiotics.  a. Therapy may requipossible changes if: (1) The organism is rechosen (2) The organism is sevents.	on log for 2019, the name of start date and end date of ed pathogen, date of culture antibiotic therapy, outcome were not captured on the log.  If a map where the residents atly were located. The ADON name for documentation ew corporate registered in the monthly clinical calling the McGeer's surveillance uary 2019." The ADON or with copies of the rently in use.  If the facility policy on antibiotic use titled "Antibiotic and Surveillance of utcomes." The policy read in the and outcome data will be ented using a facility entracking form. The data decisions for improvement antibiotic prescribing wide antibiotic stewardship.  If the appropriate use of the antibiotic and identify situations that the appropriate use of the susceptible to antibiotic and not susceptible to antibiotic	F	381	dosage, and duration of use of antibiot The use of McGeer criteria for Infection Surveillance.  Infection control surveillance and Antibiotic stewardship tracking audit wis be performed by Director of Nursing/Designee once per week for 4 weeks then once per month. The Regional Director of Clinical Operation will Audit the overall Infection Preventiand Control Program (IPCP); The annual review of the IPCP policies and practices; The review of the surveillance and antibiotic stewardship programs; and Tracking once monthly for three month. The results of the interviews and review will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to	n ill soon s. ws	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		495417	B. WING			03/	05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 881	prophylaxis; or (4) Therapy was start culture results and clineed for antibiotics.  4. All resident antibiotic documented on the fasurveillance tracking gathered will include: a. Resident name and b. Unit and room numer. Date symptoms aped. Name of antibiotic e. Start date of antibiotic e. Start date of antibiotic f. Pathogen identified g. Site of infection h. Date of culture i. Stop date j. Total days of therapek. Outcome; l. Adverse effects  A review of the line list did not include all of the either the 2018 forms  The policy also read and Implementation. 3. Appropriate indicatinclude a. Criteria met for clininfection or suspected b. Pathogen susceptis sensitivity, to antimicr.  6. When antibiotics all phone, the primary catheral culture in the primary	ed awaiting culture, but nical findings do not indicate tic regimens will be acility-approved antibiotic form. The information d medical record number aber peared bric'  esting of resident infections he above components on or the forms for 2019.  Lunder "Policy Interpretation that included: tions for use of antibiotics to iical definition of active d sepsis bility, based on culture and	F	8881			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495417	B. WING		C 03/05/2019
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	, 33.35.25.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 881	ordered, it will be co a. Lab results and the communicated to available to determine be started, continued. The surveyor intervinursing also the facion 3/5/19 at 3:18 p.r. the concern of the fastewardship program #64's clinical record ADON. A telephone "UA & C&S (urine cu Macrodantin 100 mg change Foley to 16 centimeters) balloon. The surveyor review. The urine culture results were was resistant to the prescribed [Nitrofura culture results were Resident #64 receiv. Macrodantin after the urine culture was practitioner on 12/26 Macrodantin bid on 12/27/18 at 9:00 a.m. Resident #64 receiv. days or 14 doses for that bacteria was resident.	and sensitivity (C&S) is impleted, and: in the prescriber as soon as the if antibiotic therapy should and, modified, or discontinued.  Bewed the assistant director of lity's infection preventionist in. The surveyor discussed allure of the current antibiotic in with the ADON. Resident was reviewed with the corder dated 12/20/18 read allure and sensitivity), is bid (twice a day) x 7 days, for (French) with 5 cc (cubic in with the culture results. It is showed Resident #64 current medication intoin (Macrodantin)]. The returned on 12/23/18. It is reviewed by the nurse is sold in the culture result on 12/23/18. It is reviewed by the nurse is r	F 881		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			C <b>03/05/2019</b>	
	ROVIDER OR SUPPLIER  TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COI 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE	03/03/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	DATE	
F 881	physician when the of 12/23/18 showing the (Macrodantin) was read ADON stated, "Nursicial plate when an antibital A review of the Decerosident infections of date of 12/20/18-the 12/26/18 when the of The line list also had was not done when sensitivity was obtain #64 was ordered Ro (intramuscularly) on Macrodantin was ordered was on that."  The ADON stated shantibiotic ordered was on that."  The ADON was asked seen by the physicial telephone order as postated the residents hours. A physician in 12/23/18 but a program 12/26/18 by the nursicial forming (milligrams) to Reference (Enterobact and 7 days with a cuthe medication.  Resident #64 was asked the residents forming (milligrams) to Reference for the ubacteria (Enterobact and 7 days with a cuthe medication.	curses should notify the culture came back on e antibiotic currently ordered esistant to the bacteria. The es need to step-up to the otic ordered is resistant."  Imber 2018 line list for id not include the actual start date was documented as inset of symptoms started. I documentation that a culture in fact a culture and ined on 12/20/18. Resident cephin 1 gram IM 12/26/18and prior to that, dered on 12/20/18.  The did not identify that the is resistant. "I didn't pick up in the policy. The ADON are usually seen within 24 in the was not found for itess note was written."	F 8	81			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			C 03/05/2019	
NAME OF PROVIDER OR SUPPLIER			1		REET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2019
CARRINGTON PLACE AT RURAL RETREAT				514	4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 881	disease, chronic pain muscle weakness, dif attention-deficit hyper bladder, and Vitamin  Resident #64's quarte (MDS) assessment w reference date (ARD) resident with a BIMS status) as 15/15. Resigns or symptoms of affected others or psy  The surveyor informe director of nursing, the nursing, the corporate regional executive, ar registered nurse of the day meeting on No further information exit conference on 3/8	gastro-esophageal reflux , major depressive disorder, ficulty in walking, ractivity disorder, overactive deficiency.  erly minimum data set ith an assessment of 2/6/19 assessed the (brief interview for mental sident #64 had no assessed delirium, behaviors that rchosis.  d the administrator, the e assistant director of e registered nurse, the nd the corporate MDS e above concern in the end a 3/5/19 at 4:26 p.m.	F	881			
F 921 SS=E	CFR(s): 483.90(i) §483.90(i) Other Envi The facility must prov sanitary, and comforta residents, staff and th This REQUIREMENT by:	ide a safe, functional, able environment for	FS	921	Rooms that were noticed to have odors	s	4/19/19
	complaint investigation provide an odor free of on 1 of 6 halls in the b	n, facility staff failed to environment For residents			were deep cleaned to include cleaning bedroom and bathroom.  A deep cleaning schedule was implemented on a rotating schedule fro	of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING _				C <b>03/05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	1 00/0	00/2010
CARRINGTON PLACE AT RURAL RETREAT				514 NORTH MAIN STREET			
				RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		(X5) COMPLETION DATE	
F 921	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 9	RURAL RETREAT, VA 24368  ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOLL)		s ed. s g to ng ee (3)	
				completed by the Administrat weekly for three (3) residents months to ensure residents a free from odors.  The results of the interviews will be discussed by the Direct Nursing/Designee monthly for months at the Quality Assurated Performance Improvement Composition (QAPI). The interdisticam (IDT) will make recomment for revisions as indicated necessions.	tor/Design s for three are clean a and review ctor of or three (3) ince committee ciplinary nendations cessary to	ee (3) and ws	